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A CHILD'S RIGHT TO HEALTHCARE:
THE OBLIGATION AND
ENFORCEMENT OF
INTERNATIONAL HUMAN RIGHTS
LAW

D O'BRIEN

PhD

2016

A CHILD'S RIGHT TO HEALTHCARE:
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LAW

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of the requirements of the University
of Northumbria at Newcastle for the
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Abstract

The obligation of the State to ensure children have access to healthcare is surprisingly contentious with Western capitalism demanding open markets free from interference. Such a view holds healthcare services as a commodity to be traded. A 'right' to health is only a goal to many, not a tangible guarantee States can rationally be expected to ensure because of the enormous costs and the difficulties presented to a court in adjudicating this right. On this view it is impossible for a child to have a legal right to access healthcare.

This thesis combats such arguments. The obligation of the State is discussed from a moral standpoint, finding that the child's right to health must be a State and a global obligation in any just society. Pragmatic discussion addresses the problem of legalising the obligation and showing the right can be a tangible guarantee. This is done through two paradigms: firstly, by looking at current international law and its implementation; and secondly, by looking at countries with a right to healthcare in their written constitution and adjudication of such a right. This combats the legal right arguments as well as provides lessons that international law can learn from.

This thesis contributes to discussion around the effective enforcement and implementation of human rights, especially economic, social and cultural rights. It does this by examining the scope of a child's right to health, and arguing for a moral obligation for its provision, as well as more pragmatic discussion on how to enforce such rights and adjudicate them to make them worth more than words on paper. The final chapter brings together various proposals for tackling the global challenge to ensure every child in the world has access to basic minimum healthcare.

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List of Abbreviations

ACA	Affordable Care Act
ACWA	ASEAN Commission on the Promotion and Protection of the Rights of Women and Children
AICHR	ASEAN Intergovernmental Commission on Human Rights
ARV	Antiretroviral
ASEAN	Association of South East Asian Nations
AU	African Union
CCRC	Committee on the Rights of the Child
CESCR	Committee on Economic, Social and Cultural Rights
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CJEU	Court of Justice of the European Union
CRC	Convention on the Rights of the Child
DPSP	Directive Principles of State Policy
DTP3	Diphtheria-Tetanus-pertussis
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EEC	European Economic Community

ESC	Economic, Social and Cultural
EU	European Union
GDP	Gross Domestic Product
GNI	Gross National Income
GNP	Gross National Product
GRD	Global Resources Dividend
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDA	International Development Association
IGME	Inter-agency Group for Child Mortality Estimation
IMF	International Monetary Fund
JSSK	Janani-Shishu Suraksha Karyakram
MDG	Millennium Development Goals
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organisations
NHS	National Health Service
NRHM	National Rural Health Mission
OAS	Organization of American States
OAU	Organisation of African Unity
OECD	Organization for Economic Co-operation and Development
PIL	Public-Interest Litigation
POS	Plan Obligatorio de Salud

POSS	Plan Obligatorio de Salud Subsidiado
PPP	Purchasing Power Parity
PRSP	Poverty Reduction Strategy Paper
RSBY	Rashitriya Swasthya Bima Yojana
SAP	Structural Adjustment Policy
SHI	Statutory Health Insurance
STJ	Superior Tribunal de Justiça
SUS	Sistema Único de Saúde
TAC	Treatment Action Campaign
TEU	Treaty on the European Union
UDHR	Universal Declaration of Human Rights
UNICEF	United Nations Children's Fund
VFC	Vaccines for Children Program
WCtHR	World Court of Human Rights
WHO	World Health Organization

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What started six years ago as a spark of aggressive curiosity about why America did not have a universal healthcare system given its place as a basic human right, has now become a broader thesis on a child's right to healthcare in international law. This journey has not been alone and here I get the chance to thank those who without, it would never have started and almost certainly never have finished. Firstly, I would like to thank Northumbria University Law School. The friendly staff have always been an immense help and the community of which I was made to feel very much a part has been supportive, interesting and educational. The financial and academic support from the University has not gone unnoticed and without it, this thesis simply would not exist.

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and fellow students quickly become personal friends. As a none-lawyer they have also always been very helpful and patient with whatever obvious questions I may have. They are all fantastic and I am pleased to have such great friends. A special mention should be made to Dr. Lee McConnell, who, as a former PhD student, showed me round on my first day and has helped me throughout the thesis since. His help, guidance, and friendship has varied from reading pieces of work, to reassurance that I am on track based on his experience over a pint.

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

I declare that the word count of this thesis is 83,121

Names: Dominic O'Brien

Signature:

Date: 30/08/2016

Introduction

The awareness that health is dependent upon habits that we control makes us the first generation in history that to a large extent determines its own destiny.

- Jimmy Carter

Of all of the forms of inequality, injustice in health is the most shocking and the most inhumane.

- Martin Luther King, Jr

These two quotes help explain the purpose and initial motivation behind this thesis. There are very real problems with health and children's access to healthcare, with millions of children dying needlessly every year. In highlighting this issue, this thesis is not unique; however, such an important topic can never be over-discussed. One area where this thesis does differ from more traditional discussions on health and child health is the focus on the world's richest country, the United States of America. The initial motivation to embark on this thesis was to discuss how or why America's children did not have universal access to healthcare if it was a human right? A logical corollary to this question was, what could be done to change this, and better implement and enforce international human rights law? The rationale for focusing on a country with such vast wealth will become clearer throughout the thesis and its inclusion in discussion around the poor state of children's access to healthcare, is long overdue. For too long it has been assumed that only the very poorest countries would have such a poor state of healthcare so as to warrant academic attention. The poorest countries in the world are not ignored by any means, but the US is an obligatory, over-due addition. The quotes above also help to highlight the other issues raised throughout this thesis. President Carter was right that there is so

much about health and healthcare that is within our control. Martin Luther King Jr was right to make health a matter of justice, and its inequalities therefore a shocking injustice. Combined, these help summarise the direction of this thesis; healthcare is within our control *and* is a matter of justice. As it stands, there is great inequality and injustice. Since it is within our control, we have a duty, both moral and legal, to change the current position.

The overall aims and objectives of the research in this thesis are ambitious. These are to present a highly convincing moral argument for a child's right to healthcare in international law, and subsequently, based on this substantial theory, justify stronger enforcement of the right and recommend some ways that this could be achieved. If it was to be broken down into a singular research question it would be: can we find a way to convince everyone of a child's right to healthcare, and, if so, can we find ways of ensuring it through better enforcement? In addressing such issues this thesis adopts an interdisciplinary, traditional doctrinal approach, in order to overcome some of the perceived shortcomings of existing work that examines the issues from a single perspective. For example, if the focus is largely on the philosophical, the pragmatic is often over-looked. If the focus is too much on the law, there remains a gap in recognising the moral obligation for change, and if the focus is too heavy on the sociological, it remains a comment on current affairs without legal or philosophical support for any conclusions which may be drawn. By drawing conclusions from these combined perspectives, more convincing arguments can be made that demonstrate clear current patterns to highlight obvious injustice; prove there is a legal basis that can work; provide a firm philosophical basis which makes them morally convincing; and propose pragmatic, economic proposals, that, combined with the proposed legal changes, would transform the lives of millions.

To arrive at these conclusions, the thesis is split into two parts. Part A is to explore the problem, therefore setting the issues in context and placing the rest of the thesis

within the current pragmatic setting. The research questions are very much questions of exploration to establish the current picture, such as; Is there actually a problem or difficulty in children accessing healthcare across the world? Is a child's right to healthcare an assured human right, and is this being implemented or enforced? And finally, are there comparable, domestic lessons to enforce such a right? In answering these questions in turn, chapter one of Part A commences by discussing appropriate ways to analyse healthcare systems, and then offers a brief overview of six selected countries and the healthcare systems and outcomes within them. This systemic analysis uses many readily available reports from reliable, influential and international NGOs, and as such the information is only interpreted and discussed rather than collected at source. As mentioned above, one of the key differences to normal analysis of this sort is the long overdue inclusion of the USA as a paragon of disappointment and an example of a poor healthcare system.

In chapter two the thesis reflects on the legal framework using treaty analysis followed by a review of the academic comments as to what this means in practice when discussing the content and enforcement of the right. The chapter begins with a search for the right to health, and in particular a child's right to health, within international law. It is well established that a child's right to health exists in international law but what this means in practice is not as straightforward. The mechanisms of implementation, its content, and enforcement in the case of violations are all contentious issues discussed throughout the chapter. Regional human rights law is also discussed as regional institutions can prove more successful implementers of human rights than the United Nations and international law, so the reasons why that may be the case must be analysed. One of the main conclusions from this exercise: that Europe is considered the most successful implementer of human rights largely because of the compulsory jurisdiction and overarching adjudication of the European courts, takes discussion neatly to the next

chapter, chapter three, in which; there is discussion of the adjudication of the right to health and of economic, social and cultural rights more generally. There is limited international scope for this so the focus for chapter three is on the developing countries discussed in chapter one, all of which have a right to health in their written constitutions. This is seen as an appropriate analogy to the codification of rights in the international documents considered in chapter two, and therefore can provide indicators of their justiciability by analysing the case law and in particular, the jurisprudential methods used by the judges. It will be shown how India and Brazil have encountered many problems with the adjudication of these rights, whereas South Africa has a sensible, appropriate approach, yet missed an important opportunity to include the expectation of a minimum core as part of its reasonableness analysis. It is argued that the courts can and must have a role in ensuring such rights are realised, and can do so without making decisions on matters which are usually the prerogative of a democratic government. A court's check on government and the proportionality and reasonableness of its decisions is necessary to ensure the fulfilment of rights and does not dictate what is right for the government to do; only whether the government has acted so much beyond reason as to violate a right.

Part B then moves on to addressing the problems raised in Part A. This raises more challenging research questions which are: can, even a minimal, yet strong theory of justice accommodate a child's right to healthcare, so as to provide the most convincing arguments to those who would deny the moral obligation? Can the general thesis of moral obligation and stronger judicial enforcement be applied globally? And finally, how would this global application look in practice? In answering these questions, Part B begins by moving discussion away from the current state of affairs and searching for a moral obligation of the State to ensure at least a minimal access to healthcare. This is done via a critical literature review of

political philosophy and theories of justice, in order to address issues on what should, ideally, be done, in order to support the argument for a paradigm shift in the way such rights as well as the role and obligation of the State and the global community are viewed. This ideal scenario finds its roots in John Rawls' *A Theory of Justice*; the non-traditional social contract theory that accepts its' grounding in ideal theory. The hypothetical original position is a valuable moral exercise by which to assess our world and find it lacking in many ways. The two principles of justice Rawls proposes are very minimal but our world would have to change drastically in order to fulfil them. Chapter four also undertakes the challenge of establishing that the principles of justice articulated by Rawls are bestowed upon children and not just those who are party to Rawls' social contract. Further, it is argued here that the equality of opportunity principle that Rawls proposes would naturally extend to include a right to healthcare. Absence of healthcare means that the chances of recovering from ill-health are diminished. In a state of ill-health, opportunities are limited. Therefore a lack of access to healthcare violates the opportunity principle and thus must be assured in any just society. This prominent theory is also chosen because it is, compared to many others, a minimal theory of justice and so finding a child's right to healthcare within such a theory provides even stronger support for its morality, and helps the argument for changing the philosophical mindset of those who do not see healthcare as a right, a matter of justice, or any moral obligation on the State or global community.

In the next chapter, discussion then advances to the aims of the thesis and the search for the right to health as a matter of justice, and more importantly, global justice. Firstly, chapter five lays out Rawls' global theory. This is done because whilst the thesis uses the domestic *Theory of Justice*, it rejects the international *Law of Peoples*. Accepting one part of Rawls' theory but not accepting his own extension of his own work needs justification, which can be found by using the work of other

prominent authors who argue that *A Theory of Justice* should be applied globally by its very nature. After this extension, the idea of applying a universal jurisprudence for enforcing such a right through the courts is undertaken. Here, lessons are taken from the case law discussed in chapter three, as excellent examples of adjudicating a constitutional, codified right to healthcare; lessons any judicial enforcement of the international human right to healthcare should look to learn from. This in turn, informs the development of a clear framework for an international court, or indeed any court, to follow, as adjudicating such a right is fraught with difficult challenges.

Chapter six then takes the step of making more precise proposals for change. Firstly it draws on the previous argument to apply Rawls' theory globally, which would in turn mean his difference principle; a principle stating that inequalities in wealth are only just so long as those at the minimum level are better off than they otherwise would have been. Developing some of the arguments previously raised, this thesis then proceeds with a practical economic discussion of how this is possible within the scope of the right to health. This part of the research draws on statistical analysis from readily available information and data from reliable, international organisations such as the World Bank. The richest countries in the world could afford to fund the fulfilment of a minimum core at minimal expense to themselves, and it is argued that as the World Bank and IMF are made up of States, the majority of which have ratified conventions including a child's right to health, they have a legal obligation to provide such international assistance. This connects to the subsequent discussion about the status of international law more generally and its constitutional nature. As an example of codified law, international legal documents bear a resemblance to a written constitution and Europe once again provides an example by constitutionalising its law and ensuring the doctrines of supremacy and direct effect. Discussion of the emerging but as yet ill-defined area of global constitutionalism, aims to show that the topic should unite behind a

definition of codified, ratified international law being constitutional in nature and therefore having supremacy and direct effect which can subsequently be enforced by an overarching world court. This therefore brings discussion to one of the last major proposals; a World Court of Human Rights. Such a court would have the authority to adjudicate on the right to health and would not be inappropriate in doing so as long as it used the framework proposed in chapter five. Treating international law like a written constitution and using the reasonableness structure proposed show it can be done.

The two quotes that began the introduction can be shown to be right. Part A will show that there is a great injustice in meeting a child's right to healthcare across the world, and part B will argue that the alleviation of this injustice is within our control. This thesis draws on a number of arguments previously used, but moulds them all together in order to reach a particular conclusion. Some proposals are no doubt extremely ambitious; but that does not make them wrong. In a similar way that the argument that human rights are a Western concept does not necessarily make them wrong. Change is a slow process but substantial change has never come from shying away and accepting the status quo. There is a moral and legal deficit; a moral and legal injustice in a child's right to healthcare and this is even present within the borders of the richest country in the world. This alone justifies the approach taken in this thesis and the ideas proposed. A global solution is the only just way to remove the postcode lottery of a child living or dying from preventable diseases. The only morally just solution is to accept that this is our problem too. We must accept that and rise to the challenge. Or we falter like the League of Nations and squander the possibility of changing the world forever. We stand on the precipice.

A federation of all humanity, together with a sufficient measure of social justice, to ensure health, education, and a rough equality of opportunity to most of the children born into the world, would mean such a release and increase of human energy as to open a new phase in human history.

- H. G. Wells

Part A

Exploration of the Problem

The first part of this thesis sets out the current picture, and therefore the current problem, of a child's right to healthcare. It seeks to do this through practical and theoretical means, using a multidisciplinary approach so as to address the issue from a variety of perspectives. It will be recalled from the introduction that in order to explore the problem and establish the need for such a thesis, three research questions were set out for Part A to allow better understanding of the difficulties faced, which in turns allows the proposal of solutions in Part B. As there were three research questions to explore the problem, Part A is divided in to three chapters, each with the aim of answering such questions. The first question was whether there really is a problem is children accessing healthcare around the world? In order to answer this chapter one will seek to set out the current status of children's healthcare services in various countries throughout the world. The example countries have been chosen either because they have a constitutional right to health and adjudication, or because they have a long-standing, well funded healthcare system. All six countries looked at in detail add something unique to the overall lessons this thesis seeks, namely how best to use international law to ensure and enforce a child's right to healthcare.

After this analysis of children's access to healthcare across the world, the thesis turns to address the problem from a rights perspective; more specifically from a rights theory analysis, followed by a practical discussion on the difficulties and challenges of enforcing children's rights, especially through the courts. Given the pathway and arguments of this thesis in trying to successfully enforce such rights through international as well as domestic courts, it is important that such issues are

discussed in order to explain and explore the problems faced. Chapter two concludes with a legal analysis of the current legal picture at international, regional and domestic level. Firstly it addresses the right to health in international law, including regional law, before discussing how effective such a right is. It explores this through explanation of the monitoring procedures and courts at regional level, seeking to establish the effect these have had on children's healthcare services.

Finally, in order to answer the third question on comparable, domestic lessons, national examples will be analysed, most especially in those countries discussed in chapter one that have a right to health in their written constitution as this will serve as a better example for enforcement of codified international law discussed in Part B. The legal cases at domestic level in these countries will serve as excellent lessons, both positive and negative, for further discussion in Part B on how to enforce international law possibly through an international court. Part A focuses on exploring and explaining the issues with a child's right to healthcare and seeks to do this from three perspectives; healthcare systems; problems of children's rights in theory and practice; and then enforcement mechanisms of rights when they are established. After discussing these problems the thesis moves on in Part B to discussion of change in two key areas; our philosophical thinking (which underpins and informs the second) and how to implement and enforce a child's right to healthcare.

Chapter One

Children's Access to Health Care

This first chapter sets the scene to better understand the status quo of healthcare systems around the world to help answer the first research question as to whether there is actually a problem in children's access to healthcare. This places the succeeding chapters on the need for implementing and enforcing a child's right to healthcare within the context of the current problems and locates the necessity of discussion on change. The importance and continuing problems with children's healthcare have been well documented, so much so that *The Lancet* planned a decade for the child ending in 2015 to coincide with the millennium development goals target date.¹ This chapter will look at the impact of this, if any, and any continuing problems will be highlighted in their various forms.

The first section of this chapter looks at any progress made in recent years in advancing the rights of the child to healthcare, but is limited to a small snapshot in order to give an overall idea; it does not claim to be a thorough analysis of health care status around the world. In order for even this limited scrutiny to take place, health indicators will be used with some discussion of how these might be used to measure children's healthcare with the general overarching aim of establishing a picture of the current situation. Indicators have been criticised as being vague and a possible distraction but they can also be a necessary tool in helping a country

¹ Horton R, 'The coming decade for global action on child health' (2006) 367 *The Lancet* 3, 5; see also Waterston T, and Goldhagen J, 'Why children's rights are central to international child health' (2007) 92 *Archives of Disease in Childhood* 176.

analyse the effectiveness of its healthcare system.² The subsequent brief analysis using some selected indicators will highlight very real problems, showing that discussion in this thesis and the conclusions proposed are not a purely academic exercise. Using these indicators will try and measure children's healthcare in various countries throughout the world during the course of the chapter. The aim is to provide a snapshot of healthcare status in three developing countries that have a justiciable right to healthcare, as well as three developed countries, not ignoring, as many do in such analysis, the richest country in the world, the USA. This will show that in many different countries, in different regions, and with vastly different economies, children's healthcare encounters problems. The three developing countries chosen are: South Africa, Brazil and India, and are selected because they are from different regions across the world and have an enforceable, constitutional right to healthcare which strongly resembles that found in international law so these examples are important when looking at international law, its implementation and enforcement and the comparisons that can be made to constitutional law. In 1.3, discussion moves to the three developed States to be looked at which are: the United States of America, the United Kingdom, and Germany. These are chosen because they show different ways of fully implementing a child's right to healthcare, with different policies and routes taken by the UK and Germany, as well as drawing attention to the only industrialised nation without universal healthcare coverage.³

² Committee on Economic, Social and Cultural Rights. General Comment No. 14 - the Right to the Highest Attainable Standard of Health, 2000. Vol. UN doc.E/C.12/2000/4., (hereafter General Comment 14) 43 (f); Van Bueren G, *The International Law on the Rights of the Child* (Kluwer Law International, Martinus Nijhoff Publishers 1998) 297-298; Wolff J, *The Human Right to Health* (Amnesty International Global Ethics Series, First edn, W. W. Norton & Company, Inc 2012) 32.

³ Epstein K, 'Covering the Uninsured. Can America afford to insure everyone?' (2002) 12 *The CQ Researcher* 521.

1.1 Health Indicators

Health indicators are useful for establishing a general trend in whether the measures of healthcare systems are working, but it is also important to note their weaknesses in being too generalised,⁴ and if not generalised then requiring hundreds of performance measures to be collected.⁵ They have advantages and disadvantages in that they may reflect the impact of health policy and if it is working, but they can also become an end in themselves which can lead to a reduction in overall quality of care.⁶ The UN requires continued monitoring of health outcomes as part of ensuring State compliance with the right.⁷ Yet simply stating that implementing the right includes indicators and benchmarks is part of their criticism for being vague. Deciding on the best indicators to use in order to determine the status of children's healthcare in a given country is also a very difficult task with many different suggestions having been made.⁸ One of the first places to look is the United Nations and, more specifically, to the former UN Special Rapporteur on the right to health, Paul Hunt.⁹ In 2003, Hunt began to highlight the problem:

⁴ Van Bueren (n 2) 391.

⁵ Blumenthal D, and McGinnis JM, 'Measuring Vital Signs: An IOM Report on Core Metrics for Health and Health Care Progress' (2015) *The Journal of the American Medical Association* (forthcoming).

⁶ Wolff J (n 2) 34 explains the problem of placing too much focus on achieving health indicators and sacrificing holistic healthcare. The focus is removed from the patient and their care towards statistics and achieving targets.

⁷ General Comment 14, 43 (f).

⁸ Larson C, and Mercer A, 'Global health indicators: an overview' (2004) 171 *Canadian Medical Association Journal* 1199, see especially online appendix at <www.cmaj.ca/cgi/content/full/171/10/1199/DC1> last viewed 21/09/2015.

⁹ Hunt P, and MacNaughton G, 'A Human Rights-Based Approach to Health Indicators' in: Baderin M, and McCorquodale, R., (ed), *Economic, Social, and Cultural Rights in Action* (Oxford: Oxford University Press 2007); Hunt P, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (2003) *Economic and Social Council, Contract No.: E/CN.4/2003/58*; Hunt P, 'The right of everyone to enjoy the highest

[T]here is no commonly agreed and consistent way of categorizing and labelling different types of health indicators . . . [which] represents a challenge to those who wish to introduce a simple, consistent and rational system for right to health indicators. . . . to begin with, special attention is devoted to the following categories of right to health indicators: structural indicators, process indicators and outcome indicators.¹⁰

Because of the lack of common agreement a limited account is undertaken to present a general view. Structural indicators are often yes/no questions addressing “whether or not key structures and mechanisms that are necessary for, or conducive to, the realization of the right to health, are in place.”¹¹ Process indicators look at specific programmes put in place to help indicate State effort. Examples include the proportion of skilled health personnel present at births, or women tested for HIV. Finally, outcome indicators “measure the impact of programmes, activities, and interventions on health status and related issues.”¹² Child mortality is an example of an outcome indicator and is considered by the European Committee of Social Rights and others to be a good indicator of how a country’s overall health system is functioning.¹³ So one of Hunt’s proposals is that the normal health indicators commonly used should be placed into these three categories in order to have some consistency across the literature.¹⁴

attainable standard of physical and mental health’ (2003) United Nations General Assembly, Contract No.: A/58/427; Hunt P, ‘The right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (2004) United Nations General Assembly, Contract No.: A/59/422; Hunt P, ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (2006) United Nations Economic and Social Council, Contract No.: E/CN.4/2006/48.

¹⁰ Hunt P, United Nations General Assembly, Contract No.: A/58/427 (n 9) 14-15.

¹¹ Hunt and MacNaughton (n 9) 316.

¹² Ibid 317.

¹³ Van Bueren G (n 2) 302-305; Council of Europe, *Digest of the Case Law of the European Committee of Social Rights* (2008) 82; Reinbold GW, ‘Realising Young Children’s Right to Health Under the Convention on the Rights of the Child: The Promise - and the Reality in Bangladesh and Kenya’ (2014) 22 *International Journal of Children’s Rights* 1, 6.

¹⁴ Hunt P, United Nations General Assembly, Contract No.: A/58/427 (n 9) 15; see also World Health Organization, *Consultation on Indicators for the Right to Health* (2004).

In another report in 2003, Hunt also explains that “[e]ach indicator will require disaggregation”¹⁵ to highlight any form of discrimination within the health system of a nation. This is the first step to the addition of new indicators.” Disaggregated indicators can reveal whether or not some disadvantaged individuals and communities are suffering from de facto discrimination.”¹⁶ So the two major points about health indicators Hunt proposes are setting the categories of existing indicators, and adding additional indicators to ensure that disaggregation, participation and accountability are considered. With a focus on child’s healthcare, individual participation in their healthcare is not an issue.¹⁷ Accountability will be discussed in detail in the third chapter where the justiciability of such rights and the ability of the courts to hold governments to account are considered. Therefore in this chapter, disaggregation is the only factor that needs to be added to those indicators commonly used. The World Health Organization (WHO) states: “By 2012, the same 11 indicators on reproductive, maternal and child health, disaggregated for gender and other equity considerations, are being used”.¹⁸ Of these, 7 directly affect children’s health, with 6 directly focused on healthcare and the remaining 4 more focused on reproductive and maternal health. So the 6 indicators pulled directly from the WHO which it would seem appropriate to use are:

1. Under-five child mortality, with the proportion of newborn deaths¹⁹
2. Antiretroviral (ARV) prophylaxis among HIV positive pregnant women to prevent HIV transmission and antiretroviral therapy for [pregnant] women who are treatment-eligible

¹⁵ Hunt P, Economic and Social Council, Contract No.: E/CN.4/2003/58 (n 9) 36.

¹⁶ Hunt P, Economic and Social Council, Contract No.: E/CN.4/2006/48 (n 9) 26.

¹⁷ International law is silent of the issue of child consent to medical treatment. Of course there is the issue of *Gillick* competency, which is mentioned in the next chapter, but discussion on this would deviate too much from the aims of the thesis.

¹⁸ World Health Organization, ‘Accountability for Women and Children’s Health: Recommendation 2: Health Indicators’ (2014)

<http://www.who.int/woman_child_accountability/progress_information/recommendation2/en/> last viewed 31/01/2014.

¹⁹ This is an important indicator which coincides with Millennium Development Goal 4, a call to reduce under-five mortality by two-thirds by 2015. This will help indicate if the Millennium Development Goals have been achieved.

3. Skilled attendant at birth
4. Postnatal care for mothers and babies within two days of birth
5. Three doses of combined diphtheria-tetanus-pertussis (DTP3) immunization coverage (12–23 months)
6. Antibiotic treatment for suspected pneumonia²⁰

The necessary treatments mentioned are part of what is known as the minimum core of the right to health.²¹ This means that States are under an obligation to ensure these immediately, and so in theory, as being part of the basic minimum, all the treatments should be near universal coverage which would also lead to a reduction in child mortality. Crucially, these indicators are very minimal and designed to help lower income countries realise a basic minimum of the right to health. Therefore, the indicators for higher income countries should be different, and build on these minimums, requiring more healthcare provision and better outcomes. Throughout the rest of this chapter information on these six areas in various countries across the world will be considered to see if this expectation is being met. The countries chosen offer a mixed sample of nations, with developing countries: South Africa, Brazil and India, through to developed countries: the UK, Germany, and the richest nation in the world, the United States. The developing countries are also specifically chosen because they will be used when looking at accountability and justiciability in chapter three as they have an established, constitutional right to health and offer examples of promising adjudication providing lessons for effective enforcement of international law. The developed countries provide examples of the different ways appropriate healthcare can be achieved. The exception is of course the United States, which is included because it serves as an example of what a rich country should not do, but is also undergoing some drastic changes with the entering into force of the Affordable Care Act. Equally, the failures of the US will

²⁰ World Health Organization (n 18).

²¹ General Comment 14, 43.

highlight failures of the international legal system and the somewhat hollow inclusion of a right to health.

The data used is largely provided by the UN and the WHO, which in turn is largely compiled by the Inter-agency Group for Child Mortality Estimation (IGME), which itself is led by UNICEF and the WHO, and has the World Bank and the United Nations Population Division as full members.²² This is the reason this data is used instead of other possible independent research institutes that provide different data.²³ An advantage of using this data is that it is readily available online and as it is compiled by international organisations there should not be any bias towards the State. A problem however can be accuracy, with some lack of data or data from one year changing in subsequent reports. Alkema and You have highlighted the drastic difference between country data by two different research groups, showing how the way in which data is collected has a considerable impact as well as the lack of reliable data.²⁴ Two important points about the figures need to be highlighted; firstly the rates per 1,000 births have been calculated so as to remove population difference, and secondly, the difference between the data for 1990 and 2010 have been compared, so progress, or lack thereof, can be seen. The IGME has stressed the difficulty in obtaining exact and precise child mortality data, particularly in developing countries.²⁵ It has been argued that countries need to collect this data in order to know whether they are fulfilling their obligations of progressive realisation.²⁶ It is however also accepted that in developing countries at least, the funds required

²² You D, Jones G, and Wardlaw T, *Levels and Trends in Child Mortality*. (2011) United Nations Inter-agency Group for Child Mortality Estimation 3.

²³ For example the Institute for Health Metrics Evaluation (IHME), which did not calculate for country differences with those with high HIV rates or countries in conflict where the data is particularly different to attain; see Alkema L, and You, D., 'Child Mortality Estimation: A Comparison of UN IGME and IHME Estimates of Levels and Trends in Under-Five Mortality Rates and Deaths' (2012) 9 PLOS Medicine e1001288.

²⁴ *ibid.*

²⁵ *ibid.*

²⁶ Van Bueren (n 2).

to collect this data may be better spent if allocated to providing the needed care.²⁷ Yet health measures are necessary in order to ensure countries are getting value for the vast sums of money they have to spend.²⁸ Whilst acknowledging the various concerns with data and data collection, this chapter will still try to establish a reasonably accurate picture of the status of a child's healthcare, with a caveat that it is fully recognised that it is not a thorough or complete analysis, but a snapshot to set later discussion in context.

When discussing the developed States, their basic indicators are understandably superior as they also have the resources to, and do, spend substantially more on healthcare. There are various suggested alternative indicators which are more appropriate to analyse in detail for high income countries, such as the number of individuals or households that become impoverished by healthcare costs.²⁹ This however does not take into account those who forego medical treatment because of the expense. The numbers who use health care services could be a fair indicator, however sometimes the service may not be necessary, and it has the same problem of those who forego necessary treatment through no fault of their own. The numbers who are covered and insured could be used, but this is a very simplistic measure that does not account for treatments that are actually covered.³⁰ There are therefore many different possibilities and ideas for measuring the effectiveness of the healthcare system in a developed State, all of which have potential flaws and studying these systems becomes a very complex exercise. Using what is termed 'coverage-box framework' of healthcare for context setting, how many and which people are covered, what services are covered, and what health care costs are

²⁷ *ibid* 387.

²⁸ Blumenthal D, and McGinnis JM (n 5).

²⁹ Savedoff WD, de Ferranti D, Smith, AL, and Fan V, 'Political and economic aspects of the transition to universal health coverage' (2012) 380 *The Lancet* 924, 925.

³⁰ *ibid*.

covered will be assessed.³¹ The aim will be to provide a brief snapshot of healthcare in the developed regions, to illustrate different systems and methods of implementation of the right to health, and how countries with the resources have utilised them to provide excellent healthcare to all their citizens, or show how they have, in spite of their resources, failed spectacularly. The aim for most industrialised countries and indeed many low income ones as well, has been a move towards universal coverage, the importance of which for public health cannot be underestimated.³² The term universal coverage emerged as a Western European idea in the 20th Century where access to care became recognised as a right.³³ Thus governments recognised their key role in ensuring this right and formed various ways to establish universal coverage. Despite this, many in the richest country in the world remain obstinately against the idea. It is now time to move on to the limited account of the status of healthcare systems to present a general view of very real problems.³⁴

1.2 Three Developing Countries with a justiciable right to healthcare³⁵

The three countries chosen here have established a constitutional right to healthcare in different ways within their jurisdictions and the indicators will be considered to see if any improvement in child health has followed. The mortality

³¹ Lagomarsino G, Garabrant A, Adyas A, Muga R, and Otoo N, 'Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia' (2012) 380 The Lancet 933.

³² Lagomarsino G, and others (n31).

³³ Savedoff WD, and others (n 29); many other countries have achieved universal coverage using different mechanisms such as Sweden, Malaysia, Japan and Chile.

³⁴ Hunt P, United Nations General Assembly, Contract No.: A/58/427 (n 9) 14.

³⁵ Developing Countries as labelled by IGME, UNICEF, WHO, The World Bank and the UN DESA/Population Division in You D, Jones G, and Wardlaw T (n 22).

indicators, which are examples of outcome indicators, will be looked at using the 2011 report on child mortality estimation³⁶ and the three figures the IGME have compiled for all countries, as infant mortality is considered to be a very useful indicator. Process indicators³⁷ suggested above by the WHO will also be looked at with specific programmes that indicate State effort to provide better healthcare. These include those highlighted in the indicators mentioned above, such as ARV prophylaxis and DTP3 immunization, plus vital vaccinations for children which will also be added. Data for these indicators is collected from 'Countdown 2015: Maternal, Newborn and Child Health Data', which measures health interventions to analyse achievement of the millennium development goals. These 8 well known goals offer unprecedented commitment by all countries to improve the well-being of the poorest, and of particular interest is development goal 4 which is to reduce child mortality by two-thirds between the years 1990 and 2015.³⁸ In 2013 this had reduced by 47%,³⁹ yet 1 in 5 children are still missing out on vital life-saving vaccinations worldwide.⁴⁰ In 2012 6.6 million children under the age of five died from preventable diseases, with 81% of these being in sub-Saharan Africa and Southern Asia.⁴¹ It is estimated that 1.5 million of these deaths could be prevented if the routine immunizations were received.⁴² Of the 50 countries with the highest under-

³⁶ *ibid.*

³⁷ Process indicators are those that look at specific programmes put in place to help indicate state effort against a particular healthcare concern.

³⁸ Ki-moon B, *Children and the Millennium Development Goals: Progress Towards a World Fit for Children* (2007); Reinbold (n 13) 22.

³⁹ United Nations, *Millennium Development Goals and Beyond 2015: 2013 Fact Sheet* (2013) <http://www.un.org/millenniumgoals/pdf/Goal_4_fs.pdf> last viewed 22/05/2015.

⁴⁰ World Health Organization, *Close the immunization gap: global vaccination targets off-track* (2015) <http://www.who.int/campaigns/immunization-week/2015/en/?utm_source=Twitter%20%40Vaccines&utm_medium=Social&utm_campaign=%40Vaccines%3A%20WIW%20Main%20Page> last viewed 22/05/2015.

⁴¹ United Nations, (n 39).

⁴² World Health Organization (n 40).

five mortality rate in 1990 it is suggested that only 13 were on their way to achieving their millennium development goals in 2010.⁴³

After this brief global picture, discussion now focuses on individual developing countries with a right to health as a justiciable right within their legal system. The aim of this focus is to inform arguments on the effectiveness of adjudicating ESC rights, as well as indicating potentially promising health care systems and steps these countries should take. Whilst countries generally increase their spending on healthcare in an effort to cover more and more people, this is very difficult in the poorer countries of the world. Equally it is clear that there is no one correct path towards universal coverage with many countries having different systems, yet a common denominator is increased government funding.⁴⁴ This is a problem in developing countries that have limited resources however, achieving human rights requires international cooperation which is a prominent theme frequently made throughout the thesis. The healthcare systems of three developing countries will now be discussed to see what effect, if any, their constitutional, justiciable right to healthcare has had.

1.2.1 South Africa

South Africa and Brazil have the right to healthcare written in their modern constitutions, and this is becoming increasingly common with 69% of written Constitutions now containing a right to health, 41% of which are stated as justiciable.⁴⁵ For South Africa, this right is in Section 27 under Chapter 2 entitled 'Bill

⁴³ Reinbold (n 13) 23.

⁴⁴ Lagomarsino G, and others (n 31).

⁴⁵ Jung C, Hirschl R, and Rosevear E, 'Economic and Social Rights in National Constitutions' (2014) 62 *American Journal of Comparative Law* 1043, 1052.

of Rights' which "enshrines the rights of all people" in South Africa.⁴⁶ Section 27 of the Constitution is entitled "Health care, food, water and social security" and begins with:

1. Everyone has the right to have access to
 - a) health care services, including reproductive health care; . . .
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
3. No one may be refused emergency medical treatment.⁴⁷

This has been considered a justiciable right in practice as well,⁴⁸ the significance of which will be established in chapter three, but it is clear that the Constitution envisages a government obligation to provide all its citizens with healthcare, including, and some argue especially, children.⁴⁹ However this has not been the case with the current system in South Africa being divided between private insurance schemes and under-resourced public services.⁵⁰ Despite only covering a small percentage of the population the private schemes have accounted for the greatest proportion of the total health expenditure in the country highlighting the large disparity between rich and poor in South Africa. It is well known as one of the most unequal societies in the world and this carries over to healthcare as the outcome indicators suggest. The public sector provides care for those who cannot afford health insurance and do not receive it through employment and this equates to around 80% of the population, despite representing less than half of the total

⁴⁶ Constitution of the Republic of South Africa, (1996) Chapter 2.

⁴⁷ *ibid* section 27.

⁴⁸ See for example; *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 (CC).

⁴⁹ *Grootboom v Oostenberg Municipality and Others* 2000 (3) BCLR 277 (C); see also Constitution of the Republic of South Africa, (1996) Chapter 2, section 28 (c) which establishes specifically the rights of children to basic healthcare services.

⁵⁰ McIntyre D, and Ataguba JE, 'Modelling the affordability and distributional implications of future health care financing options in South Africa' (2012) 27 Health Policy and Planning 101, 102.

health expenditure in the country.⁵¹ The private sector serves the remainder of the population and has substantially more resources for significantly less people. The rates for healthcare indicators between 1990 and 2010 reduced very little. The under-five mortality rate reduced from 60-57 per 1,000 live births, the infant mortality rate dropped by 6, and the neonatal mortality rate stayed exactly the same according to the figures available.⁵² This is only a general picture and the data may be inaccurate, but from what information can be gathered, the general trend in child mortality in South Africa is disappointing, given the promising inclusion of the right to health care within its Constitution.

However in some areas children's healthcare does appear to have improved. The main positive has to be the prevention of mother to child transmission of HIV which has increased drastically in just a few short years, from 49% coverage in 2007 to over 95% in 2011.⁵³ That clear steps have been taken to help this improvement may be directly attributable to the benefits of having a justiciable constitutional right to healthcare, and the decision in *Minister of Health v Treatment Action Campaign*⁵⁴ forced the government to provide the drug Nevirapine to mothers giving birth in State facilities. In this case failure by the government to dispense the drug was found to be unreasonable as it was being provided for free to the State and its safety and effectiveness could not be legitimately questioned. Thus the government was ordered by the court to dispense the drug more widely than it had been. The importance of such treatment in South Africa is easily seen when it is highlighted

⁵¹ Human A, 'A Tale of Two Tiers: Inequality in South Africa's Health Care System' (2010) 2 University of British Columbia Medical Journal 33.

⁵² Data in this table is from: You D, Jones G, and Wardlaw T (n 22); see also Kumar Paul V, Singh Sachdev H, Mavalankar D, Ramachandran P, Jeeva Sankar M, Bhandari N, Sreenivas V, Sundararaman T, Govil D, Osrin D, and Kirkwood B, 'Reproductive health, and child health and nutrition in India: meeting the challenge' (2011) 377 The Lancet 332, 333; These rates are per 1,000 live births, and the infant mortality rate is deaths under one year of age, and the neonatal mortality rate is calculated from deaths under 28 days.

⁵³ Countdown to 2015: Maternal Newborn and Child Survival, *Accountability for Maternal, Newborn and Child Survival: The 2013 Update* (2013) 93.

⁵⁴ 2002 (5) SA 721 (CC).

that “[i]n 2011, an estimated 70.4% of maternal deaths in South Africa were associated with HIV infection, as were half of all deaths of children younger than 5 years.”⁵⁵ There is therefore still much more that can be done, but it is clear steps in the right direction have been made. In 2010, the first South African national survey on overall mother to child transmission rate was carried out and found to be 3.5%. In 2011 this had already reduced to 2.7%.⁵⁶ The cost of ARV treatment was then reduced in 2012 for the second time, having already been reduced by the government in 2010, making the cost 53% lower in just two years.⁵⁷ It is to be expected that the rate of mother to child transmission should reduce even further as more women will be able to afford the treatment, although 15% of public healthcare facilities still did not offer this treatment in 2012.⁵⁸ Therefore, there is still more to be done despite clear steps in the right direction.

Other areas of concern in South Africa include the absence of any improvement in key immunisation programmes since 2010.⁵⁹ Although the 2013 profile for South Africa suggests recent improvements, this comes after a drop in the percentage of immunized children, bringing the total back to what it was in 1990. This is disappointing, but there also may be legitimate reasons. It may be that the government cannot afford to increase the numbers of vaccinations, or that it has not been increased because something else was prioritised and a difficult resource choice has had to be made. The child mortality rates are also disappointing but the ARV prophylaxis shows how impressive progress can be made by having a right to

⁵⁵ Barron P, Pillay Y, Doherty T, Sherman G, Jackson D, Bhardwaj S, Robinson P, and Goga A, 'Eliminating mother-to-child HIV transmission in South Africa' (2013) 91 Bulletin of the World Health Organization 70, 70-74; Stephen CR, Bamford LJ, Patrick ME, and Wittenburg DF, *Saving children 2009. Five years of data. A sixth survey of child healthcare in South Africa* (2011).

⁵⁶ Barron P, and others, (n 55).

⁵⁷ UNAIDS, feature story; 'South Africa's savings in procurement of antiretroviral drugs to increase access to treatment for people living with HIV' <<http://www.unaids.org/en/resources/presscentre/featurestories/2012/november/20121130zatreatmentprices/>> last viewed 21/09/2015.

⁵⁸ Barron P, and others, (n 55).

⁵⁹ Countdown to 2015 (n 53).

healthcare enforceable against the State. This will be discussed in more detail in chapter three. Equally promising is the ongoing change in South Africa with proposals for a national health insurance scheme as a step towards universal coverage.⁶⁰ A green paper was released in 2011 on national health insurance with the idea to phase in various schemes over the next 14 years, requiring the richest to contribute more to the scheme even if they do not use it themselves. The limited data in South Africa combined with the fact that this will be progressively rolled out means the impact of this has not yet been seen, but it is a promising step no doubt encouraged by an enforceable, justiciable right to healthcare. This brief portrait using the limited data available to illustrate a general point that children's healthcare in South Africa over the last 20 years or so has improved in some areas, failed to improve in others, and requires more analysis and data collection.

1.2.2 Brazil

For Brazil the establishment of a Constitutional right to healthcare began in 1985 when dictatorship ended, and then in 1986 the 8th National Health Conference declared health to be 'the duty of the state and the right of the citizen'.⁶¹ In 1988 the new Brazilian Constitution established a right to health in two provisions: in Article 6 which establishes many social rights including education and shelter; and then in Articles 196-200 which are specific to the right to health. Article 196 states:

Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the

⁶⁰ Mills A, Ataguba JE, Akazili J, Borghi J, Garshong B, Makawia S, Mtei G, Harris B, Macha J, Meheus F, and McIntyre D, 'Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage' (2012) 380 *The Lancet* 126; McIntyre D, and Ataguba JE, (n 50).

⁶¹ Cornwall A, and Shankland A, 'Engaging citizens: Lessons from building Brazil's national health system' (2008) 66 *Social Science & Medicine* 2173, 2175.

universal and equal access to actions and services for its promotion, protection and recovery.⁶²

This subsequently led to the introduction of the Sistema Único de Saúde (Unified Health System, known as the SUS) formed in 1990 as a “universal, publicly-funded, rights-based system”,⁶³ and there can be little doubt that it has had a large impact on the health indicators of Brazil and has been considered an outstanding success.⁶⁴ It can be seen that Brazil has made the most improvements of the developing States looked at here, more than halving all the outcome indicator rates since 1990. One contributing factor to this is a focus on a family health programme meaning that in some areas pregnant women attend 10 prenatal appointments.⁶⁵ All the child mortality rates have more than halved in the 20 years from 1990 and the immunisation rates are at near universal levels.⁶⁶ Despite the promising statistics from Brazil there is still some suggestion that there is much to be improved upon with Cornwall and Shankland stating:

There is still much to be done to improve health equity. Significant inequalities have persisted despite improved access, with marked differentials in health indicators becoming evident when the data are disaggregated by gender, race, income and region. Middle-class consumption of private health insurance has grown hugely since the introduction of the SUS, with private spending rising faster than public spending.⁶⁷

⁶² 1988 Constitution of the Federal Republic of Brazil, translation from the original, in Portuguese, Art. 196. (A saúde é direito de todos e dever do Estado, garantido mediante políticas sociais e econômicas que visem à redução do risco de doença e de outros agravos e ao acesso universal e igualitário às ações e serviços para sua promoção, proteção e recuperação); see also Prado MM, 'The Debatable Role of Courts in Brazil's Health Care System: Does Litigation Harm or Help?' (2013) 41 Journal of Law, Medicine and Ethics 124, 135 footnote 2.

⁶³ Cornwall A, and Shankland A, (n 61); see also *Permanent Mission of Brazil to the United Nations Office and Other International Organizations in Geneva* (2011) Geneva: Office of the High Commissioner for Human Rights
<<http://www2.ohchr.org/english/issues/women/docs/responses2ndNV/Brazil.pdf>>last viewed 21/09/2015.

⁶⁴ World Health Organization, 'Flawed but fair: Brazil's health system reaches out to the poor' (2008) 86 Bulletin of the World Health Organization 248, 248.

⁶⁵ *ibid*, 249.

⁶⁶ Countdown to 2015 (n53) 39; You D, Jones G, and Wardlaw T (n 22).

⁶⁷ Cornwall and Shankland (n 61) 2175.

So clearly the disaggregation of health indicators mentioned above becomes an issue for Brazil, but progress is being made as in 2000 a Constitutional Amendment guaranteed a rising share of government revenues to the SUS by setting minimum percentages the government is required to spend on health.⁶⁸ Whilst there is still some work to be done, there can be no doubt that Brazil has made impressive steps on health in recent years and the SUS is the main reason. The same authors concede this, applauding the drastic fall in the child mortality rates and a National Household Survey (Pesquisa Nacional por Amostra de Domicilios) recording an increase in numbers recording that they had accessed health services.⁶⁹ As promising as this is, it will be seen later that this has come at substantial cost. Part of this cost is health expenditure increase which whilst necessary has been decided by the Courts. This has established a jurisprudence where only those fortunate enough to have access to the Courts receive the needed care. Therefore the increase in healthcare is concentrated on those who can afford to apply to the Court, which in turn has led to an increase in litigation and many similar cases being decided. This will be further discussed in chapter 3.1.2 where the strong criticisms and potential problems of adjudicating a right to health in such a way will be addressed.

1.2.3 India

Unlike South Africa and Brazil, India does not have an explicit, justiciable right to health or healthcare in its Constitution. Article 39 (e) mentions the health of workers, Article 39 (f) ensures children are given the opportunity to develop in a healthy

⁶⁸ Constitutional Amendment No. 29 which modifies Article 198 on the Constitution; see also Cornwall and Shankland (n 61) 2175; Campelli MG, and Calvo MC, 'Compliance with constitutional amendment 29 in Brazil' (2007) 23 *Cad Saude Publica* 1613.

⁶⁹ Cornwall and Shankland (n 61) 2174.

manner, and Article 42 provides maternity relief,⁷⁰ but there is no specific protection or provision of the right to healthcare. However the right to health is protected in India via an extension of the right to life in Article 21. The jurisprudence of this will be further discussed in chapter three, but I find the Article odd in that it moves from the right to life to then ensuring a child's right to education in 21A.⁷¹ Article 21A is an amendment to the Constitution added after the Supreme Court read the right to education as part of the right to life. Interestingly the legislature has decided not to make a similar amendment with any other extensions the Court has made of the right to life. However, the impact of these extensions and particularly reading the right to health in to the right to life provided by the courts in India can be seen by analysing the state of children's healthcare.

India has a mixed system for healthcare in a way similar to South Africa and America, however, the State contribution has been very limited with public spending on healthcare persistently low.⁷² Equally the private sector is not large enough to cover the majority of the population and most Indians have no insurance and so out-of-pocket expenditure in India is one of the highest in the world.⁷³ It is suggested that only 10-15% of Indians have health insurance which is provided through employers or some government schemes for selected employment groups.⁷⁴ This has led to a situation where the best possible health care is available to the few who

⁷⁰ The Constitution of India, (as modified up to the 1st December 2007) Government of India, Ministry of Law and Justice.

⁷¹ *ibid*, Article 21: 21. Protection of life and personal liberty.—No person shall be deprived of his life or personal liberty except according to procedure established by law.

21A. Right to education.—The State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine.

⁷² Mudur G, 'India plans to move towards free universal healthcare coverage' (2011) 343 *BMJ* 343.

⁷³ Balarajan Y, Selvaraj S, and Subramanian SV, 'Health care and equity in India' (2011) 377 *The Lancet* 505, 508; Yip W, and Mahal A, 'The Health Care Systems Of China And India: Performance and Future Challenges' (2008) 27 *Health Affairs* 921, 928.

⁷⁴ Balarajan Y, Selvaraj S, and Subramanian SV (n 73) 508-509; Yip W, and Mahal A (n 73) 927.

can afford it, whereas the poorest lack even basic essential services.⁷⁵ The private sector is run by large corporations which seemingly have a monopoly on the market and are therefore in control of India's healthcare system, especially given the absence of an effective public service.⁷⁶ The cost of healthcare becomes impossible for many because of the unregulated private sector⁷⁷ leading to a scenario where one stay in hospital can cost more than a year's salary for many Indians.⁷⁸ Because of this situation and the low spending by India's government there have been many calls for India to move towards a universal healthcare system and drastically increase its spending, especially given its recent economic growth.⁷⁹ Some proposals and plans put forward will be discussed below, such as the National Rural Health Mission aiming to more than double government spending on healthcare,⁸⁰ but the timing of these fairly recent calls mean that their impact remains to be seen.⁸¹

It is clear looking at the limited statistics available that there are many problems facing the state of children's healthcare in India with commentators in *The Lancet* calling India's outcome figures 'unacceptably high'.⁸² Some progress has been made with the infant and under-five mortality rate which has decreased drastically and nearly halved over the 20 years from 1990, and with slight improvements in the neonatal mortality rate.⁸³ However only around 50% of births are attended by skilled

⁷⁵ Sirinath Reddy K, Patel V, Jha P, Paul VK, Shiva Kumar AK, and Dandona L, 'Towards achievement of universal health care in India by 2020: a call to action' (2011) 377 *The Lancet* 760, 761.

⁷⁶ Sengupta A, and Prasad V, 'Towards a truly universal Indian health system' (2011) 377 *The Lancet* 702, 703.

⁷⁷ Sirinath Reddy K, and others (n 75) 761.

⁷⁸ Yip W, and Mahal A (n 73) 923.

⁷⁹ Sengupta A, and Prasad V (n 76); Sirinath Reddy K, and others (n 75); Balarajan Y, Selvaraj S, and Subramanian SV (n 73); Yip W, and Mahal A (n 73).

⁸⁰ Yip W, and Mahal A (n 73) 929.

⁸¹ Ministry of Health and Family Welfare, *National Rural Health Mission: Meeting People's Health Needs In Partnership With States: The Journey So Far 2005-2010* (2010); Balarajan Y, Selvaraj S, and Subramanian SV, (n 73).

⁸² Sirinath Reddy K, and others (n 75).

⁸³ You D, Jones G, and Wardlaw T (n 22).

personnel, and the percentage of children inoculated against measles and DTP3 remains less than 75%.⁸⁴ Postnatal care is also stated as only 37%,⁸⁵ which may be a contributing factor to the smaller improvement and reduction in neonatal mortality. In a similar way to South Africa there may be legitimate reasons for this which will be discussed in chapter three, but it remains clear there are still many problems.

India also currently spends only 1.2% of its GDP on publicly funded healthcare⁸⁶ compared to Brazil's 4.2% and South Africa's 3.9%.⁸⁷ Yet within the past decade there has been some promise in India with the government committing to increase its spending to 3% GDP over the next few years,⁸⁸ and with the introduction of the National Rural Health Mission (NRHM) in 2005, the Rashtriya Swasthya Bima Yojana (RSBY, National Health Insurance Programme) in 2008, and the Janani-Shishu Suraksha Karyakram (JSSK) in 2010.⁸⁹ The NRHM provides budget support and aims to provide affordable primary healthcare to the rural population⁹⁰ and had the specific aim of halving infant mortality by 2012, which it did not quite achieve but a large reduction resulted nonetheless.⁹¹ The RSBY was aimed at giving poor families more access to healthcare and in 2010 more than 14 million people were automatically signed up as beneficiaries of this system.⁹² It relies on private insurers for fully subsidised, via general taxes, in-patient care to the poorest.⁹³ One problem with such programmes that focus on helping the poor, which are found in many

⁸⁴ Countdown to 2015 (n 53) 63.

⁸⁵ *ibid.*

⁸⁶ Gill J, and Taylor D, *Health and Health Care in India: National opportunities, global impacts* (2013) UCL School of Pharmacy; see also OECD 2010 Health Data, <http://www.oecd-ilibrary.org/economics/country-statistical-profile-india_csp-ind-table-en>.

⁸⁷ OECD (n 86).

⁸⁸ Ministry of Health and Family Welfare *Report of the working group on health care financing including health insurance for the 11th five year plan* (2006) 9; see also Shiva Kumar AK, Chen LC, Choudbury M, Ganju S, Mahajan V, Sinha A, and Sen A, 'Financing health care for all: challenges and opportunities' (2011) 377 *The Lancet* 668.

⁸⁹ Gill J, and Taylor D (n 86) 22-23; see also Balarajan Y, Selvaraj S, and Subramanian SV (n 73) 511.

⁹⁰ Lagomarsino G, and others (n 31) 934.

⁹¹ Gill J, and Taylor D (n 86) 22; see also Shiva Kumar AK, and others (n 88) 674.

⁹² Gill J, and Taylor D (n 86) 23; Lagomarsino G, and others (n 31).

⁹³ Lagomarsino G, and others (n 31).

countries including America, is identifying who is poor enough to qualify and ensuring they know they are eligible and therefore enrol.⁹⁴ The JSSK is aimed at women and babies, increasing deliveries in public health institutions and also child immunization rates.⁹⁵ These government programmes are very promising initiatives, the impact of which may not yet have been seen,⁹⁶ especially with the limited data available and only providing a brief overview of some areas. The programmes are a clear response to the increasing politicalisation of healthcare in India which has been at least aided by the courts establishing a right to healthcare which will be further discussed in chapter three.

1.2.4 Concluding Remarks on healthcare in Developing Countries with a Justiciable Right to Health

The outcome indicators have improved in all three countries with Brazil and India showing the most drastic improvements, particularly in under-five and infant mortality rates in India, and with Brazil more than halving all these rates over 20 years. The reductions in South Africa are very small in comparison and disappointing over a 20 year period, but, whilst the rates are still high, as will be seen more when the developed countries are considered, overall clear improvements and progression can be seen. These numbers also correlate with those on the Countdown to 2015 reports and the 2013 Accountability Profiles.⁹⁷ The

⁹⁴ Kenney GM, Lynch V, Cook A, and Phong S, 'Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?' (2010) 29 Health Affairs 1920; Lagomarsino G, and others (n 31).

⁹⁵ Gill J, and Taylor D (n 86) 23; see also Government of India: Ministry of Health and Family Welfare *Annual Report to the People on Health* (2011) 6 and 17.

⁹⁶ Balarajan Y, Selvaraj S, and Subramanian SV (n 73) 511.

⁹⁷ Countdown to 2015: Maternal, Newborn and Child Survival, *Building a Future for Women and Children: The 2012 Report* (2012); see also Countdown to 2015 (n 53); see also Countdown to 2015: Maternal, Newborn and Child Survival, *Fulfilling the Health Agenda for Women and Children. The 2014 Report* (2014).

correlation between these figures is promising because it may suggest more accurate data across the board where figures are available.

One of the more striking things from the statistics available is what is missing. Where there is no information on postnatal care in South Africa or Brazil, this has to be a matter of concern given the importance of this health care indicator. As the WHO points out:

Up to two-thirds of the 3.1 million newborn deaths that occurred in 2010 can be prevented if mothers and newborns receive known, effective interventions. A strategy that promotes universal access to antenatal care, skilled birth attendance and *early postnatal care* will contribute to sustained reduction in maternal and neonatal mortality.⁹⁸

The only statistic available shows that only 37% of births in India receive appropriate postnatal care, which, regardless of any improvement, is very low and must be seen as disappointing.⁹⁹ The impact of postnatal care cannot be known in countries that do not measure it, with existing problems therefore remaining unseen and whether or not a country is reaching the recommendations of the WHO and UNICEF similarly unknown.

Additionally, ARV prophylaxis has only been measured in South Africa, which should be commended on its drastic improvement. Antiretroviral (ARV) prophylaxis is necessary to prevent mother to child HIV transmission and the substantial improvement in this area in South Africa has made it the best throughout the

⁹⁸ WHO programmes, Maternal, newborn, child and adolescent health, postnatal care <http://origin.who.int/maternal_child_adolescent/topics/newborn/postnatal_care/en/index.html>last viewed 21/09/2015, emphasis added. The quote continues “A little less than half of all mothers and newborns in developing countries do not receive skilled care during birth, and over 70% of all babies born outside the hospital do not receive any postnatal care.”

⁹⁹ The Lancet reports 51% of women receiving any postnatal care in 2007-2008 in India, which means that either the number has decreased, or 14% of those women are receiving insufficient postnatal care; see Kumar Paul V, and others (n 52) 339.

continent.¹⁰⁰ This improvement is in no small part due to the justiciability of the right to healthcare in South Africa which will be further discussed in chapter three.¹⁰¹

Skilled attendance at birth has also improved in all three countries, with South Africa and Brazil achieving above 90%, which is very promising. India has improved but still has a long way to go only reaching 52% in 2008. This is an important indicator for the quality of maternal and child healthcare and the variations are seen across other developing countries as well, ranging from below 50% in Kenya and Nigeria, to 88% in Vietnam.¹⁰² The quote from the WHO above,¹⁰³ highlights the importance of this early healthcare and this low percentage increase may account for the limited improvement in neonatal mortality over the same 20 year period in which there was a much greater reduction of infant and under-five mortality rates in India.

Finally the percentage of children receiving antibiotics in cases of suspected pneumonia is either very low or the data is absent, meaning this is clearly an area requiring improvement in all three countries. South Africa once again shows disappointing data collection, with the only data available being a clear decrease in the numbers of children being taken to an appropriate health provider when suspected of having contracted pneumonia.¹⁰⁴ This is clearly a concerning retrogression. Once again more substantial data collection is needed to better indicate the state of children's healthcare in South Africa. Further retrogression is seen in India which actually shows a decrease in the percentage of children receiving antibiotics, whereas in Brazil the retrogression comes from ceasing to collect data.

¹⁰⁰ Countdown to 2015: *The 2012 Report* (n 97) 174-5; Countdown to 2015 (n 53) 17.

¹⁰¹ For example see *Minister of Health v Treatment Action Campaign* 5 SA 721 (CC) (2002).

¹⁰² Lagomarsino G, and others (n 31).

¹⁰³ WHO programmes (n 98).

¹⁰⁴ Countdown to 2015 (n 53) 93.

So these process indicators show mixed results with perhaps South Africa appearing the best with the drastic improvement in ARV prophylaxis and improving the skilled attendant at birth rate. Brazil and India also improved in that indicator, yet for India the rate of 52% is still far too low. After these positives it is the lack of data that leads to mixed results. Failure to measure such important health indicators should be a concern. It is clear from this data that Brazil has made the most improvement with near universal immunization for those recommended by the WHO. South Africa most disappointingly has made no improvements and actually a slight decrease in DTP3 immunization, whereas India has made only small improvements with no data for Hib.¹⁰⁵

Overall it seems Brazil has made the most improvements over the last 20 years, improving all the outcome indicators, including the three mortality rates, by more than half, improving the skilled attendant at birth and immunization percentage to near universal levels. India has improved the outcome indicators with a similar drastic reduction to Brazil, however the skilled attendant at birth improvement is still far too low. South Africa has been disappointing in the mortality rates and immunization, yet has made vast improvements in ARV prophylaxis and skilled attendant at birth rates. All 3 countries need to improve and measure postnatal care and the numbers of children with suspected pneumonia receiving antibiotics, with measurement of ARV prophylaxis also being something to improve for Brazil and India, with no data being available. These are important statistics to miss if they are placed on the WHO's health indicators list and so failure to measure them is not encouraging. However, overall positives can be seen in all three countries although more can and must be done with better data collection being vital to know exactly what help may be needed. It now follows to discuss the healthcare systems of three

¹⁰⁵ *Countdown to 2015* has published data on the WHO indicators and taken it a stage further also highlighting immunization against measles and Hib. *Haemophilus influenzae* type b, an important cause of childhood meningitis and pneumonia.

developed regions to highlight two key areas: that high spending without an effective healthcare policy does not produce positive results; and that there must be a margin of appreciation in realising the right to healthcare as different systems can be equally effective.

1.3. Developed Regions (United States, Germany, and the United Kingdom)

Typically when discussing a minimum core human right such as a child's right to healthcare, developed regions are ignored because it might be presumed there is complete fulfilment by responsible, accountable, and powerful governments with extensive resources at their disposal. Given that in 2012 some 6.6 million children had no health insurance at all in the United States,¹⁰⁶ this omission seems unwarranted. These children are much less likely to have a regular source of medical care, receive necessary preventive medicine, or have seen a doctor in the last year and are more likely to have unmet health needs which in many cases will only exacerbate.¹⁰⁷ In the United States this uninsured number is after considering those children covered by both private and public sector coverage programmes, such as the Children's Health Insurance Program (CHIP), and is of course before the implementation of the well documented Patient Protection and Affordable Care

¹⁰⁶ DeNavas-Walt C, Proctor BD, and Smith JC *Income, Poverty, and Health Insurance Coverage in the United States: 2012* Washington DC.: U.S. Census Bureau (Current Population Reports, 2013) 29. This number is also a large reduction of the 8.1 million that were without any health insurance in 2008, which maybe because of an extension of SCHIP in early 2009 by President Obama.

¹⁰⁷ Kasper J, and Wise PH, 'The Relevance of the United Nations Convention on the Rights of the Child for United States Domestic Policy: Welfare Reform and Children in Immigrant Families' (2001) 5 *Health and Human Rights* 64, 74; Newacheck PW, Pearl M, Huges DC, and Halfon N, 'The role of Medicaid in ensuring children's access to care' (1998) 280 *The Journal of the American Medical Association* 1789; Newacheck PW, Stoddard JJ, Huges DC, and Pearl M, 'Health insurance and access to primary care for children' (1998) 333 *The New England Journal of Medicine* 513.

Act of 2010, which came into force in 2014.¹⁰⁸ The fact that the richest country in the world had 6.6 million children with no health insurance at all at any point in the year of 2012 is a justifiable reason for considering the state of children's healthcare in developed countries as well as those in the less affluent parts of the world. The goal of developed countries should be universal coverage; stepping stones towards everyone having access to necessary healthcare. It will be shown that there are different ways this can be achieved and that the United States has done none of them to the extent required.

1.3.1 The United Kingdom

It is expected that developed States will have much better health facilities and therefore health indicators than has been seen so far in the developing regions and this is indeed the case.¹⁰⁹ For example in the UK the child mortality rates have all reduced slightly over the 20 years 1990, but even in 1990 they were all below 1%.¹¹⁰ Neonatal mortality was just 3 per 1000 live births in 2010.¹¹¹ This promising healthcare continues with immunisation rates at above 90%,¹¹² however it is difficult to comment on data in all the other areas measured above as this does not seem to be collected. Countdown to 2015, for example, has only focused on certain developing regions and their commitment to the Millennium Development Goals. The limited country profiles provided by the WHO however, do suggest the superior state of healthcare in the three developed countries selected which is to be expected in a country that spends so much on healthcare. A quick indicator using

¹⁰⁸ H.R. 3590 signed by President Obama on 23rd March 2010.

¹⁰⁹ General Comment 14, 12 (a).

¹¹⁰ You D, Jones G, and Wardlaw T (n 22).

¹¹¹ *ibid.*

¹¹² WHO Global Health Observatory Data Repository, Immunization: Diphtheria tetanus toxoid and pertussis (DTP3) by country
<<http://apps.who.int/gho/data/node.main.A827?lang=en>> last viewed 21/09/2015.

total health expenditure¹¹³ should illustrate the difference.¹¹⁴ Using the OCED data to consider PPP, the UK spends US\$3405 per capita on health, as opposed to South Africa's US\$ 942, Brazil's US\$1043 or India's very disappointing US\$141. The extra spending allows for a much stronger healthcare system and leads to clearly superior health outcomes.

In the UK, coverage is universal. All those who are "ordinarily resident" are covered by the National Health Service (NHS) which is largely free at the point of delivery and covers:

preventive services; inpatient and outpatient (ambulatory) hospital (specialist) care; physician (general practitioner) services; inpatient and outpatient drugs; dental care; mental health care; learning disabilities; and rehabilitation.¹¹⁵

Most of the costs of the NHS are met through general taxation,¹¹⁶ accounting for 87% of total health expenditure, but private health insurance is also available, and "[i]n

¹¹³ According to the World Bank: "Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in current U.S. dollars." <<http://data.worldbank.org/indicator/SH.XPD.PCAP>> last viewed 21/09/2015.

¹¹⁴ Whilst data available from the World Bank and WHO are the same, the OCED data is quite different. This is because the OECD includes Purchasing Power Parity (PPP) in its' calculations which adjusts the exchange rate so it can consider each currency's purchasing power. It is a more accurate measure as in essence it considers the value of, or what you can purchase for one US\$ in, for example, Norway and it is not just a flat exchange rate. This addition makes quite a large difference to the data. The World Bank data suggests that Switzerland and Norway spend more than the US on health per capita, whereas the US is commonly accepted as having the most expensive healthcare system in the world (n 113); Davis K, Stremikis K, Squires D, and Schoen C, *Mirror, Mirror On The Wall: How the Performance of the U.S. Health Care System Compares Internationally* (The Commonwealth Fund, 2014) 7, 11. See also, Reinhardt UE, Hussey PS, and Anderson GF, 'U.S. Health Care Spending In An International Context' (2004) 23 Health Affairs 10; Compare World Bank data (n 113) and Organization for Economic Co-operation and Development *Health at a Glance 2013: OECD Indicators*, (2013) 155.

¹¹⁵ The Commonwealth Fund *International Profiles of Health Care Systems: Australia, Canada, Denmark, England, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States* No. 1417(2010) 19.

¹¹⁶ It was originally designed to be funded via payroll taxes but because of its success and growth the government decided to rely on its general revenues, see Savedoff WD, and others (n 29).

2006, it covered 12 percent of the population and accounted for 1 percent of total health expenditure.”¹¹⁷

1.3.2 Germany

Whilst Germany has a slightly different healthcare system to that of the UK, the results are very similar. The basic indicators are once again exceptional with the mortality rates being below 5 per 1000 live births and the immunisation also being near universal.¹¹⁸ Again, given the money spent this should be expected with expenditure being US\$4495 per capita.¹¹⁹ Both the UK and Germany are above the OECD average which leads to an expectation of a good healthcare system that provides plenty of coverage. In Germany, mandatory health insurance has been gradually introduced to cover different aspects of the population since Otto von Bismarck’s social legislation in 1883,¹²⁰ but it was the Statutory Health Insurance Competition Strengthening Act 2007 that put in force universal mandatory insurance.¹²¹ All employed citizens that earn less than €53,500 per year are covered by the Statutory Health Insurance (SHI) which is the mandatory public health insurance scheme, and their dependents, spouses and children, are covered free of charge.¹²² Those earning beyond this are required to attain private health insurance. Also known as the Bismarck model after their former Chancellor who espoused the

¹¹⁷ The Commonwealth Fund (n 115) 19.

¹¹⁸ You D, Jones G, and Wardlaw T (n 22); WHO Country Profiles <<http://www.who.int/countries/en/>> last viewed 21/09/2015; WHO Global Health Observatory Data Repository (n 112).

¹¹⁹ OECD (n 114) 155.

¹²⁰ Tulchinsky TH, and Varavikova EA, 'National Health Systems', *The New Public Health* (Third edn, Elsevier Academic Press 2014) 674.

¹²¹ Lisac M, Reimers L, Henke K-D, and Schlette S, 'Access and choice - competition under the roof of solidarity in German health care: an analysis of health policy reforms since 2004' (2010) 5 Health Economic, Policy and Law 31, 37.

¹²² Osborn R, and Anderson C, *International Profiles of Health Care Systems, 2014: Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Singapore, Sweden, Switzerland, and the United States* No. 1802 Mossialos E, and Wenzl M, (ed), (The Commonwealth Fund, 2015) 64.

idea, it relies on funds from household premiums, payroll taxes as well as private providers.¹²³ This scheme, combined with mandatory insurance has led to universal coverage for all permanent residents of Germany.¹²⁴

The SHI scheme covers about 85 percent of the population. Around 10 percent of the population is covered by private health insurance, with civil servants and the self-employed being the largest groups. The remaining persons, e.g., soldiers and policemen, fall under special regimes.¹²⁵

The healthcare services covered in Germany are as substantial and similar to the NHS. The financing comes from around 130 “sickness funds” which “are private, not – for – profit insurance companies that collect premiums from employees and employers.”¹²⁶ Employees earning up to €48,600 a year contribute 8.2% of their annual wage to sickness funds, with the employer contributing a further 7.3%.¹²⁷ To help those not covered by this scheme or who cannot afford the mandatory insurance, there has been an increase in the amount of tax-financed federal subsidy for “insurance extraneous benefits provided by the SHI (especially coverage of children). These expenses are considered to be of common interest and therefore are (partly) covered from general taxes.”¹²⁸ It now seems appropriate to move on and consider the US, because it has been suggested that:

The German experience is especially relevant to the United States. Coverage is provided through a large number of relatively small and independent plans. In this sense, the delivery of health care is similar to that found in the United States . . .¹²⁹

¹²³ Lagomarsino G, and others (n 31) 935.

¹²⁴ Osborn R, and Anderson C (n 122) 63.

¹²⁵ The Commonwealth Fund (n 115) 28.

¹²⁶ Ridic G, Gleason S, and Ridic O, 'Comparisons of Health Care Systems in the United States, Germany and Canada' (2012) 24 *Materia Socio Medica* 112, 114; see also, DiFlorio CV, 'Assessing Universal Access to Health Care: An Analysis of Legal Principle and Economic Feasibility' (1992) 11 *Dickinson Journal of International Law* 139, 146-148; Osborn R, and Anderson C (n 122) 63.

¹²⁷ Osborn R, and Anderson C (n 122) 64.

¹²⁸ The Commonwealth Fund (n 115).

¹²⁹ Ridic G, Gleason S, and Ridic O (n 126) 114.

However, unlike Germany, and as indicated above, this system of health care provision in the US led to 6.6 million children being uninsured and without any health coverage in 2012, which is before the Affordable Care Act 2010 came into force in 2014.

1.3.3 The United States

The basic indicators for the United States are substantially better than those seen in developing countries, yet perhaps surprisingly worse than those seen in the UK and Germany.¹³⁰ The difference is not substantial, but given the large amount of money the US spends on health, the outcomes should be even better. The mortality rates are below 10 but not as good as Germany at below 5 per 1000.¹³¹ Immunisation is at similar levels to the UK and Germany at above 90%.¹³² One point to address first is that being without health insurance does not mean having no healthcare at all in the United States. This is largely because of various government programmes that are universal and is one of the main reasons why the statistics make US healthcare appear to be of a similar standard to that in the UK and Germany. The same or slightly lower very basic health outcomes are being achieved, even though the United States spends US\$8508 per capita on health.¹³³ The United States has the most expensive health care system in the world,¹³⁴ and also has the highest mortality rates in all three categories of the three developed countries discussed, despite spending roughly \$3,500-\$4,000 per capita more than Germany and roughly \$5,000 per capita more than the UK. It is unclear exactly why the US spends so

¹³⁰ You D, Jones G, and Wardlaw T (n 22); WHO Country Profiles <<http://www.who.int/countries/en/>> last viewed 21/09/2015; WHO Global Health Observatory Data Repository (n 112).

¹³¹ You D, Jones G, and Wardlaw T (n 22).

¹³² WHO Country Profiles (n 130); WHO Global Health Observatory Data Repository (n 112).

¹³³ OECD (n 114) 155.

¹³⁴ Davis K, and others (n 114) 7 and 11.

much more on healthcare with studies showing it is not because of more health resources, more physicians, hospital beds or more expensive medical equipment,¹³⁵ but more likely the general high prices of care which have made it more and more unaffordable to many Americans.¹³⁶ If this is considered alongside the 6.6 million children that had no health insurance in 2012, it seems fair to say that the United States does not see much return on outcome indicators for its exceptional spending.¹³⁷

The prevailing view in America is a priority for civil and political rights over economic, social and cultural rights such as healthcare.¹³⁸ In the US, healthcare is a commodity that can be purchased and it is not a right the State has an obligation to provide.¹³⁹ Finding such an obligation even on a minimal theory of justice should help inform a different conclusion even with the minimalist and negative American political principles, and will be further argued at the end of this section. Offering an alternative, contrary approach is one of the aims of this thesis. The important pieces of legislation specifically relevant to the basic health indicator statistics are the Comprehensive Childhood Immunization Initiative Act and the Omnibus Budget Reconciliation Act 1993, brought in by President Bill Clinton.¹⁴⁰ These Acts ensure federal purchase and universal distribution to all children of all recommended childhood vaccines, which will account for the high percentage of vaccinations despite the numbers of uninsured children. Prior to these initiatives the goal of

¹³⁵ Anderson GF, Hussey PS, Frogner BK, and Waters HR, 'Health Spending In The United States And The Rest Of The Industrialized World' (2005) 24 Health Affairs 903.

¹³⁶ Reinhardt UE, Hussey PS, and Anderson GF (n 114).

¹³⁷ Davis K, and others (n 114) 11; see also Yamin AE, 'Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care' (2008) 10 Health and Human Rights 45, 53.

¹³⁸ Kasper J, and Wise PH (n 107) 78.

¹³⁹ Rudiger A, and Meier BM, 'A Rights-Based Approach to Health Care Reform' in Beracochea E, Weinstein C, and Evans DP, (ed), *Rights-Based Approaches to Public Health* (Springer Publishing Company 2011) 70.

¹⁴⁰ Robinson CA, Sepe SJ, and Lin KFY, 'The President's Child Immunization Initiative - A Summary of the Problem and the Response' (1993) 108 Public Health Reports: Policy 419.

vaccinating all children at the appropriate ages was not being achieved,¹⁴¹ with an actual decrease in 1984 in the percentage of 1-4 year olds who had been immunised due to a decrease in federal funding and a rise in the price of vaccinations.¹⁴² Fortunately, this led to the two 1993 Acts.¹⁴³ The second of these Acts created the Vaccines for Children Program (VFC) which provided funding for the State to purchase vaccines from manufacturers and administer them to 10.6 million children a year for free.¹⁴⁴ “Within 3 years, VFC providers collectively vaccinated >75% of US children using a combination of VFC vaccine and vaccine purchased with private and other funds.”¹⁴⁵

These funds and programmes help with the basic health indicators that make the figures and statistics similar to the UK and Germany. However, the introduction of Medicaid and Medicare in 1965 by Lyndon B. Johnson was first designed to provide health coverage to the lowest income families and people with disabilities.¹⁴⁶ The impact of the Medicaid legislation on children’s health can be seen in the drastic reduction of infant mortality in the US, from 29.2 per 1000 live births in 1950, to 10.8 in 1984.¹⁴⁷

¹⁴¹ Robinson CA, Evans WB, Mahanes JA, Sepe SJ, 'Progress on the childhood immunization initiative' (1994) 109 Public Health Reports 594.

¹⁴² Roemer R, 'The Right to Health Care - Gains and Gaps' (1988) 78 American Journal of Public Health 241, 244.

¹⁴³ Hinman AR, Orenstein WA, and Rodewald L, 'Financing Immunizations in the United States' (2004) 38 Clinical Infectious Diseases 1440.

¹⁴⁴ Robinson CA, and others (n 141) 597.

¹⁴⁵ Hinman AR, Orenstein WA, and Rodewald L (n 143) 1442.

¹⁴⁶ Medicaid is often considered alongside Medicare which is a programme for every American over 65 introduced in the same amendments of the Social Security Act. Before Medicare, 48% of Americans over 65 had no health insurance; today that number is 2%, with Medicare covering 55 million people. It took nearly 20 years for the Medicare bill to be passed as it was first championed by President Truman when he was in office. It is not a panacea, nor does it provide a perfect universal healthcare system for over 65's as many still supplement Medicare with other insurance packages, although they are less likely to experience burdensome medical bills they cannot afford. Title XVIII Social Security Act establishes Medicare whereas Title XIX established Medicaid; Rudiger A, and Meier BM (n 139) 72. See also, Davis K, Schoen C, and Bandeali F, *Medicare: 50 Years of Ensuring Coverage and Care* (The Commonwealth Fund, 2015) 9-11.

¹⁴⁷ Roemer R (n 142) 244.

Before more detail on the Medicaid expansion under the recent Affordable Care Act (ACA) is discussed, another Act passed by Bill Clinton must be considered: The State Children's Health Insurance Program Act of 1997, now known as the Children's Health Insurance Program (CHIP).¹⁴⁸ This was designed to "insure children in families with too much income to qualify for Medicaid and too little to afford private insurance."¹⁴⁹ This can account for a 4% decrease in the number of children with no health insurance since 1994.¹⁵⁰ In 2008 it was estimated that 65% of uninsured children were eligible for CHIP or Medicaid.¹⁵¹

Some of the latest figures available report that Medicaid covers over 62 million Americans, which includes Medicare cover, and 31 million children. "All told, Medicaid and the smaller Children's Health Insurance Program (CHIP) cover 1 in every 3 children."¹⁵² It is suggested by Medicaid.gov, a federal government website, that, CHIP provides health coverage to nearly 8 million children and the Agency for

¹⁴⁸ Medicaid.gov, Children's Health Insurance Program <<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Childrens-Health-Insurance-Program-CHIP.html>> last viewed 08/01/2015; see also, National Conference of State Legislatures, Children's Health Insurance Program <<http://www.ncsl.org/research/health/childrens-health-insurance-program-overview.aspx>> last viewed 21/09/2015.

¹⁴⁹ Lambrew JM, *The State Children's Health Insurance Program: Past, Present, and Future* (The Commonwealth Fund, 2007) vi; see also Medicaid.gov <<http://www.medicaid.gov/CHIP/CHIP-Program-Information.html>> last viewed 21/09/2015.

¹⁵⁰ Glennon T, and Schwartz RG, 'Foreword: Looking Back, Looking Ahead: The Evolution Of Children's Rights' (1995) 68 Temple Law Review 1557, 1558; in 1994 almost 13% of children had no health insurance, in 2012, with 73.7 million children and 6.6 million without insurance, the number is closer to 8.95%. CHIP was set to expire at the end of the fiscal year 2007, but there were calls to reauthorise and expand CHIP however details could not be agreed and all expansion efforts were vetoed by President George W. Bush. As a compromise, the programme as it was, was extended through to March 2009. Then, within weeks of his inauguration, President Barack Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA) on 4th February 2009. The Act provided significant new funding for the programme as well as directed funding to ensure all eligible children were enrolled on such programmes. See, National Conference of State Legislatures (n 148). Medicaid.gov (n 148).

¹⁵¹ Kenney GM, and others (n 94).

¹⁵² The Henry J. Kaiser Family Foundation *The Medicaid Program at a Glance* (The Kaiser Commission on Medicaid and the Uninsured, 2013).

Healthcare Research and Quality stated that 39 million children are covered by both Medicaid and CHIP so these numbers correlate.¹⁵³

However, despite these government programmes showing that some healthcare is available to those without insurance, underinsurance, costs of care and fear of medical debt are still major problems.¹⁵⁴ The problem of underinsurance means that individuals, including children on an inadequate family plan, may have to delay or forgo treatment because they cannot afford to pay for it out-of-pocket, and their insurance does not cover it, or the financial cap from the insurance is too low.¹⁵⁵ One report states people have had to raise their insurance deductible to \$10,000 in order to afford any coverage at all. This means that they are expected to pay for anything up to \$10,000 before the insurance plan pays anything for any medical treatment. People with high deductibles are much more likely to report that they have not been able to receive, or made a choice to forego, needed medical care because of cost.¹⁵⁶ Out of pocket expenditure is one of the leading causes of healthcare poverty and the WHO advises that it should not reach above 20% of total health expenditure.¹⁵⁷ In 2012 the US was at 11.1%, but this somewhat glosses over the problems of out of pocket expenditure the country has,¹⁵⁸ which links to another, spiralling issue of the American insurance system; increasing homelessness due to medical bills.

¹⁵³ Medicaid.gov (n 148); see also Agency for Healthcare Research and Quality *Children's Health Insurance Program Reauthorization Act (CHIPRA)* <<http://www.ahrq.gov/policymakers/chipra/index.html>>last viewed 21/09/2015; This has now changed to an estimated 45 million which no doubt is an impact of the expansion of Medicaid under the Affordable Care Act, yet precise figures remain to be established.

¹⁵⁴ Davis K, and others (n 114) 8.

¹⁵⁵ Vermont Workers' Center *Voices of the Vermont Healthcare Crisis: The Human Right to Healthcare* (2008).

¹⁵⁶ Rasmussen PW, Collins SR, Doty MM, and Beutel S *Health Care Coverage and Access in the Nation's Four Largest States* (The Commonwealth Fund, 2015); Collins SR, Rasmussen PW, Doty MM, and Beutel S *Too High a Price: Out-of-Pocket Health Care Costs in the United States* (The Commonwealth Fund, 2014).

¹⁵⁷ World Health Organization *The World Health Report 2010. Health Systems Financing: the path to universal coverage* (2010).

¹⁵⁸ WHO Global Health Observatory Data Repository (n 112).

The relationship between healthcare and homelessness is a vicious cycle that is difficult to break, under the current healthcare system. A typical scenario is a situation in which an individual becomes ill, cannot access necessary medical care, is unable to work – or fired – and consequently becomes unable to pay for housing. The individual is then forced onto the streets, where his health deteriorates.¹⁵⁹

A report by the Commonwealth Fund also focuses on this issue and the lack of equity with the American healthcare system because of an inability to pay. In the report, which compares 11 high income countries, America ranks last in the performance of its' healthcare system. The report highlights those Americans who fall through the gaps in the American insurance system and states that those with below-average incomes were much less likely to seek necessary medical care. In the 2014 report, "one-third or more lower-income adults in the U.S. said they went without needed care because of costs in the past year."¹⁶⁰

This highlights just some of the problems of the insurance system in the United States, leading to a large number of uninsured people who have to forgo necessary treatment,¹⁶¹ or make large sacrifices in order to do so, and this does not exempt children. "In a system where health services are sold for profit on the market and financed through private insurance and individual payments, access and availability of health care inevitably remain restricted to those who can pay."¹⁶² These problems are before the implementation of the Affordable Care Act in 2014, the full impact of which remains to be seen.

The Affordable Care Act 2010¹⁶³ is the main reason the German model was discussed above, because like Germany, the ACA also made health insurance

¹⁵⁹ *ibid* 22.

¹⁶⁰ Davis K, and others (n 114) 9.

¹⁶¹ Vermont Workers' Center (n 155) 10-11.

¹⁶² Rudiger A, and Meier BM (n 139) 74-75.

¹⁶³ The legislation is specifically two Acts, The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act.

compulsory with a few exemptions.¹⁶⁴ It also offers a large expansion of Medicaid, offering coverage to adults aged 19-64 whose incomes are at or below 138% of the federal poverty level.¹⁶⁵ However, when the Supreme Court ruled that the ACA was constitutional,¹⁶⁶ they unexpectedly added limitations of the ability of the Department of Health and Human Services to enforce it, thus the decision to opt for such expansion lies with individual states within the US.¹⁶⁷ The debate around the ACA has unfortunately been partisan and focused on concern for providing universal coverage.¹⁶⁸ Of the 50 states in the US, 19 have still opted *not* to expand Medicaid in 2016,¹⁶⁹ despite the large amounts of federal funding that will be granted. “[S]tates will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years.”¹⁷⁰ This expansion was part of the deal to make health insurance compulsory, as well as the offer that individual states can provide less comprehensive cover than the federal level to those who become newly eligible for Medicaid under the ACA.¹⁷¹ Fortunately, the states that

¹⁶⁴ “Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual’s income, and those with incomes below the tax filing threshold”; see The Henry J. Kaiser Family Foundation *Summary of the Affordable Care Act. Focus on Health Reform* (2013) 8061-02.

¹⁶⁵ Rosenbaum S, Mehta D, Dorley M, Hurt C, Rothenburg S, Lopez N, and Ely S, ‘Medicaid Benefit Designs for Newly Eligible Adults: State Approaches’ (2015) 11 Commonwealth Fund Publication 1815 1.

¹⁶⁶ *National Federation of Independent Business v Sebelius* 567 U.S_ (2012).

¹⁶⁷ The Henry J. Kaiser Family Foundation (n 164); see also Blumenthal D, *The Affordable Care Act: What Are the Facts After Five Years?* (The Commonwealth Fund, 2015) <<http://www.commonwealthfund.org/publications/blog/2015/may/aca-facts-after-five-years>> last viewed 30/09/2015; see also, *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.* certiorari to the united states court of appeals for the eleventh circuit no. 11-393. argued march 26, 27, 28, 2012-decided june 28, 2012. The supreme court stated that requiring states to comply with the new law or risk losing their funding was only constitutional if states would lose new funds rather than all funding.

¹⁶⁸ Blumenthal D (n 167).

¹⁶⁹ The Henry J. Kaiser Family Foundation <<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>> last viewed 02/04/2016

¹⁷⁰ The Henry J. Kaiser Family Foundation (n 164) 1.

¹⁷¹ Rosenbaum S, and others (n 165).

have opted for expansion go beyond this new minimum set by the ACA to comparable levels of coverage previously held.¹⁷² Without this expansion across the country, many will fall through the cracks between state coverage and being able to afford a private health plan, and children will suffer too. This why in 2012, 48 million Americans had no health insurance, and as mentioned 6.6 million of these were children.¹⁷³ The Commonwealth Fund provides a brief overview of the impact of the failure to expand Medicaid in the individual states, with Texas, for example, losing \$9.217 billion of funding available and leaving an estimated 1,046,430 people falling through the coverage gap.¹⁷⁴ Thus the subsequent drops in uninsured rates differ greatly among states. New York and California for example, have expanded Medicaid and now have uninsured adult rates of 12% and 17%, compared to Florida and Texas with no expansion and uninsured rates of 21% and 30% respectively.¹⁷⁵ More than 3 million Californians have gained Medicaid coverage since 2013,¹⁷⁶ and it is estimated that as of March 2016, 20 million previously uninsured people have gained coverage since the bill was passed in 2010.¹⁷⁷ It remains difficult to comment

¹⁷² *ibid.*

¹⁷³ DeNavas-Walt C, Proctor BD, and Smith JC (n 106) 29; see also US Census Bureau: Health Insurance <<http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2012/highlights.html>> last viewed 21/09/2015. In 2014, because of the refusal to expand Medicaid, 51% of low-income adults in Texas were uninsured. The refusal to expand Medicaid despite the Federal funding available also follows party lines in America and the Republican Party ideology that healthcare is not a right but a commodity that can and should be bought and sold in a free market place. Of the 19 states that have opted against expansion, only 4 voted Democrat in the 2012 US presidential election. Of the 31 states that have opted for expansion the last being Louisiana in January 2016, only 9 voted Republican in the same election. See, Rasmussen PW, and others (n 156); BBC News, US Election Results ; The Henry J. Kaiser Family Foundation <<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>> last viewed 02/02/2015.

¹⁷⁴ The Commonwealth Fund 'New State-by-State Analysis: States Rejecting Medicaid Expansion Under the Affordable Care Act Are Costing Their Taxpayers Billions' (2013) <<http://www.commonwealthfund.org/publications/press-releases/2013/dec/states-rejecting-medicaid-expansion-costing-taxpayers>> last viewed 02/04/2016

¹⁷⁵ Rasmussen PW, and others (n 156).

¹⁷⁶ Lytle EC, Roby DH, Lucia L, Jacobs K, Cabezas, and Pourat N, *Promoting Enrollment of Low Income Health Program Participants in Covered California* (UCLA Center for Health Policy Research, 2013); Rasmussen PW, and others (n 156).

¹⁷⁷ Uberoi N, Finegold K, and Gee E, Health Insurance Coverage and the Affordable Care Act, 2010–2016 (Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Issue Brief)

definitively on the impact of the bill at this early stage,¹⁷⁸ yet there are some projections that by 2017, 26 million previously uninsured people in the US will be covered.¹⁷⁹

1.3.4 Concluding Remarks on Healthcare Systems in Developed Countries

Without the expansion of Medicaid, it will remain the case in the United States that the highest earners of the lowest income families and those in low-middle income families will struggle to obtain health coverage of any kind. Even where previously uninsured are brought within the programme there may be those who have serious physical or mental health problems because their conditions went untreated for so long whilst they were uninsured.¹⁸⁰ These people need coverage the most and the fact that the states have actively rejected such expansion is troubling, especially considering the money available to them. The US may pass the minimal test with the vaccination programmes brought in, and the fact that emergency care will always be available (although a large bill may be forthcoming subsequently if there is no insurance),¹⁸¹ but it cannot be contentious to expect better health outcomes from a country that spends \$8,508 per capita compared to the \$3,405 of the UK. As it is, the mortality rates in the US are higher than in the UK, many still have no health cover, and despite the Affordable Care Act, many may still fall through the gaps.¹⁸²

¹⁷⁸ Blumenthal D (n 167); Osborn R, and Anderson C (n 122) 161.

¹⁷⁹ Osborn R, and Anderson C (n 122) 153; Davis K, and others (n 114) 26.

¹⁸⁰ Rosenbaum S, and others (n 165).

¹⁸¹ Vermont Workers' Center (n 155) 10.

¹⁸² This can all be considered alongside the slow rate of change to rectify a clear problem in the United States, with Medicaid being established in 1965, and it then taking until 1993 for the Comprehensive Childhood Immunization Initiative and until 1997 for the Children's Health Insurance Program, and 2010 for the Affordable Care Act. Over a 45 year period

This may not be all that surprising when it is considered that it was not until the middle of the twentieth century and the *In re Gault*¹⁸³ case that children were considered persons under the Fourteenth Amendment to the American Constitution.¹⁸⁴ All of these changes however, may still not ensure that the \$8,508 per capita spent on health provides every child in the United States with the substantially more comprehensive healthcare of similar countries that spend significantly less, such as the UK and Germany.

DiFlorio discusses the politics of America and why their political tradition has led to the current healthcare system, but in using this competitive tradition he makes the moral arguments that will be made in part B of this thesis:

Premised on a commitment to the principle of equal opportunity, “minimum welfare” is presumably a notion embraced by even the American moral perspective. The American political tradition is one based upon competition. In this spirit, the principle of minimum welfare simply provides that each person should have a fair chance to play the game and to compete with others on the basis of his or her talents and abilities. But in order to have an equal opportunity to compete, a person must at least have an opportunity to develop his or her capabilities. Without the fulfillment of certain basic needs, such as food, education, and health care, people are prevented from developing their capabilities and are thus excluded from the game of competition. Therefore, justice requires that “basic” needs be provided to all so that there is equal opportunity to develop within the system. Clearly, the security of basic medical care, like public education and social security, must be accessible to each individual if the competition, inherent in our society, is to be fair and just.¹⁸⁵

As if to reiterate this idea, Brassington has mentioned how social contract thinking, the model which Rawls’ theory of justice ascribes to, played its part in the

there have been just a few pieces of healthcare legislation passed that have drastically improved the state of children’s healthcare in the US.

¹⁸³ *In re Gault* 387 U. S. 1 (1967) by extending due process rights to children.

¹⁸⁴ Appell AR, 'Uneasy Tensions Between Children's Rights and Civil Rights' (2004) 5 Nevada Law Journal 141; However in 1899, Cook County, Illinois established the first separate Court for children in the US, and this continued with 47 states following suit in the next twenty years; see also Glennon T, and Schwartz RG (n 150) 1560.

¹⁸⁵ DiFlorio CV (n 126) 153.

development of American independence.¹⁸⁶ Thus, it will be shown that there should be a clear establishment of the right to basic healthcare, even on a minimal theory of justice and through the scope of American political tradition. Yet it is clear that the language of a *right* to healthcare is still problematic and controversial in the United States, despite its international recognition.¹⁸⁷ Equally it has been shown that this right is not being fulfilled in many countries in the world. Therefore this thesis must eventually look at how to fulfil the right and enforcement mechanisms. These arguments can be seen as ways to ensure a country is fair and just. A country can only be considered just if it fulfils the basic obligations of a theory of justice. The aim of this thesis is to provide the most convincing arguments against healthcare being a capitalist commodity, using a theory I believe most people will find most convincing at its core. If this argument can be made, it may be the persuasive position needed to convince even the most ardent Republican of the United States that healthcare is a right, not a commodity. Before making this argument however, it is important to continue considering the current problem and position of a child's right to healthcare in international law in order to establish the requirement of 'addressing the problem' through different philosophical, legal and political thinking, in Part B.

¹⁸⁶ Brassington I, *Public Health and Globalisation: Why a National Health Service Is Morally Indefensible* (Societas, Imprint Academic 2007) 66.

¹⁸⁷ Leary VA, 'The Right to Health in International Human Rights Law' (1994) 1 Health and Human Rights 25, 30.

Chapter Two

Children's Right to Health Care

2.1 Children's Rights Theory

2.1.1 Do Children Have Rights?

It is not simply enough to state that children have rights. The purpose of the previous chapter was to demonstrate the real problem and the futility of simply accepting that a written right to healthcare for children is enough of a guarantee or that discussion of the topic should be limited to the current legal circumstance. Words on paper are meaningless, as is the right itself unless the origin of the right is understood. This is why any thesis that does not engage with the philosophy of the right will be limited, and why Rawls theory is subsequently used in this thesis to tip the balance in favour of a minimal right to healthcare for children. Without such consideration, "[c]hildren's rights is a slogan in search of a definition."¹ This now brings discussion to the rights of children; the theory and practice of those difficult rights which helps to locate this work within the scope of children's rights literature.

Recalling the single research question in the introduction, it was asked firstly if we could find a way to convince everyone of a child's right to healthcare? This is because it is vital that we find a way to convince everyone that children have rights, and that healthcare is one of them. Arguing for the right's of the child has two parts; philosophical, and legal. The philosophical debate is important to underpin any legal rights that may be found and convince people of their firm foundation as, without this, any legal rights may be unenforced and meaningless. This chapter explores

¹ Rodham H, 'Children Under the Law' (1973) 43 Harvard Educational Review 487.

these two parts of children's rights, beginning with the philosophical debate around whether children can even have rights at all and discussing the two competing theories of rights; interest and choice (or will) theory.

In Rawls' theory of justice, discussed later, the fact that children are not contractors, and that the rights that arise from the principles of justice may differ slightly, does not lead to any reason why the principles should not be bestowed on children. The main focus here is on protection and fulfilling interests, rather than autonomy or capacity for such interest fulfilment.² In this way the principles can be bestowed on everyone as this comparison is very much an interest theory conception of rights, where a *sufficient* interest in something is the grounding and justification of a *right*.³ It is important to discuss this theory to understand where the rights of the child may come from. Joseph Raz, the main proponent of interest theory, argues that the interest must be "a sufficient reason for holding some other person(s) to be under a duty."⁴ The right is established in between them as an intermediate conclusion, as Raz explains: "[T]he interests are part of the justification of the rights which are part of the justification of the duties. Rights are the intermediate conclusions in arguments from ultimate values to duties."⁵ From this it can be seen how an interest moves to a right, and a right to a duty. Rights are legally protected interests that imply obligations on duty holders to observe them.⁶ Rights are intermediate conclusions between interests and duties, and as such, a key point of interest

² See Archard D, 'The Moral and Political Status of Children' (2006) 13 Public Policy Research 6; Van Bueren G, The International Law on the Rights of the Child (Kluwer Law International, Martinus Nijhoff Publishers 1998) 3.

³ Federle KH, 'Looking Ahead: An Empowerment Perspective on the Rights of Children' (1995) 68 Temple Law Review 1595, 1598 rightly points out that not all interests will generate rights.

⁴ Raz J, 'On the Nature of Rights' (1984) XCIII Mind 194, 195.

⁵ *ibid* 208.

⁶ Easley CE, Marks SP, and Morgan Jr RE, 'The Challenge and Place of International Human Rights in Public Health' (2001) 91 American Journal of Public Health 1922.

theory can be seen: that rights talk can take place antecedent of duties because they are the “*reasons for the duties to which they give rise.*”⁷

Interest theory allows children to be rights-holders as they have clear sufficient interests leading to rights. So if we agree or believe that children have rights, we need an interest theory conception because the main alternative, choice, or will, theory⁸ focuses on the upholding of autonomy and as such does not allow room for younger children to be rights-holders,⁹ meaning it is not the appropriate conception to lean on for underpinning a child’s right to health. Interest and choice (will) theory, are the only two, main theories on what is known as the function of rights; what rights do for those who hold them and therefore, who can hold them. Children cannot have rights on choice theory because if they were to have the freedom to make bad choices, that would surely be detrimental to their welfare and be against society’s obligations towards them.¹⁰ The key to a right within choice theory is control and/or autonomy. Rights serve to protect a certain measure of freedom/control the right-holder enjoys by dint of their capacity as an *active manager*, a choosing agent, within a realm defined by the right.¹¹ Choice theorists argue that people are the “active managers of their own lives even when to do so will work to their overall detriment”,¹² thus the upholding of autonomy is central to the theory. Contrastingly it is argued that under the interest theory individuals become “passive beneficiaries of the services of others”.¹³

⁷ Jones P, *Rights: Benefits, Choices and Titles* (Macmillan Press 1994) 29.

⁸ Hart HLA, 'Are there and natural rights?' (1955) 64 *The Philosophical Review* 175.

⁹ Archard D (n 2) who highlights that some philosophers contend that it is fundamentally mistaken to think of children having rights.

¹⁰ Federle KH (n 3) 1588. The debate goes back hundreds of years between these two theories of right, with philosophers such as Kant, Hart and Kelsen on the will theory side, and Bentham, Austin and Raz on the interest theory side. See Wenar, Leif, "Rights", *The Stanford Encyclopedia of Philosophy* (Fall 2015 Edition), Edward N. Zalta (ed.), <<http://plato.stanford.edu/archives/fall2015/entries/rights/>>last viewed 26/08/2016

¹¹ *ibid* 1586.

¹² Sumner LW, *The Moral Foundation of Rights* (Clarendon Press 1987) 97.

¹³ *ibid*.

Yet it is argued here that interest and choice theory, despite such fundamental differences in the basis of a right, need not be incompatible. Interest theory could place autonomy as an interest, which can then put others under a duty not to interfere, but at the same time it can be argued that autonomy is the core and most important part because to have interests that are worthwhile, or 'sufficient', one must first be autonomous. Autonomy may therefore seem to supersede all other rights and interests. There does appear to be some circularity here and possibly an irresolvable intertwining between interests and autonomy. Do we have an interest in being autonomous because we are autonomous? Or does our autonomous nature make us realise that it was because people had a duty to protect our interests in the past that allowed us to become autonomous beings at all? Choice theorists believe a right only comes from having control over someone's duty. But contrastingly it can be said that they have an *interest* in controlling someone's duty, and so such rights may exist within interest theory, if this interest is seen as sufficient. Given this connection between interests and autonomy, a focus on protecting future autonomy is not as difficult for children's rights as might be first thought because it can be said children have a sufficient interest in their future autonomy being protected, leading to clear rights and duties of others by ensuring things such as education and healthcare.

Another important difference between the two theories is unwaivable rights. Choice theorists, as 'active managers', believe any rights we possess can be waived by us, and that if a 'right', such as not to be assaulted, cannot be successfully waived, it is not a right. As such there is no right not to be murdered, or not to be enslaved, but choice theorists do not therefore condone murder or enslavement (the difference between what is right, and a right). They argue the language must be different, and that something not being protected by a right, does not mean others do not have a duty against doing it. If this idea is brought out of moral philosophy and into

pragmatic legal thought, then it may seem more palatable and sympathetic. Whilst there is no such thing as legal murder,¹⁴ where the right not to be murdered is waived by the victim, we (in the UK) have the right to medical treatment, but we also have the right to refuse medical treatment – that is to waive our right to medical care.¹⁵ Thus we can control our rights, or at least certain rights. Whilst appealing, this is not without problems in that in order to be able to control our rights, right-holders must necessarily be fully autonomous persons. Hence the debate of whether children truly have rights.

The bestowing of rights upon children is one of the major advantages of interest theory. Wenar has suggested that choice theory is ‘implausibly narrow’ because it does not give children rights as they do not have the necessary capacity to exercise their rights.¹⁶ He argues:

Few would insist that it is conceptually impossible, for example, for children to have a right against severe abuse. . . . The appeal of the interest theory emanates from the wide range of rights that it can endorse, and from the evident fact that having rights can make a life go better.¹⁷

Hart, who originally propounded choice theory, subsequently changed his views on the concept of a right in respect of moral rights, reportedly suggesting rights “may be used to focus upon individuals’ needs rather than upon their possessing

¹⁴ In the same way as there is no legal assault or actual bodily harm; see *R v Brown* [1994] 1 AC 212 where the key issue was whether the consent given was considered valid, to which the court answered in the negative as there can be no consent to such acts as to render them legal. The key word above is murder. Things that may appear to be legal murder will actuarially be called something else. It is not always illegal or immoral to kill someone, but it is always illegal and immoral to murder someone.

¹⁵ At least for adults. Children generally do not have this right as they are not considered to have *de jure* autonomy (legal right to self-government) and so decisions are made by third parties on their behalf. See Hollingsworth K, ‘Theorising Children’s Rights in Youth Justice: The Significance of Autonomy and Foundational Rights’ (2013) 76 *The Modern Law Review* 1046, 1058. However in the UK we have developed the interesting yet heavily criticised dilemma where mature minors (16 and 17 year olds especially) can consent to medical treatment and not require parental consent (Family Law Reform Act 1969, Section 8) but cannot refuse medical treatment. See, *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112 House of Lords.

¹⁶ Wenar L, ‘The Nature of Rights’ (2005) 33 *Philosophy & Public Affairs* 223, 239.

¹⁷ *ibid* 240-241.

choices.”¹⁸ This would suggest that Hart also agrees that children therefore have moral and legal *rights* for something which is ‘focused upon their needs.’

Choice theorists however would rebut that such non-right-holders are still afforded protection by non-correlative obligations, that is, obligations that are not derived from any right.¹⁹ Every right *may* inform a corresponding duty, yet not every duty therefore is informed by a right. Such non-correlative obligations are necessarily held by the autonomous right-holders. Sumner, for example, incorporates relational duties based on a benefit analysis into his view of choice theory, leaving us with a result he hopes will negate such problems:

[A]lthough a theory of rights which adopts the choice model can make no sense of the rights of . . . infants or young children or the severely mentally handicapped, it can accomplish essentially the same objective by making them the beneficiaries of our protective duties.²⁰

Such protective duties may seem to make the theory more palatable. However there is more to the rights of children than negative duties and obligations by adults not to harm them. For example, protective duties make no room for the right to education or healthcare as these are positive, beneficial rights based on a child’s interests. The negative obligations and protective duties not to physically and/or actively harm children will not stretch to such a right as healthcare, certainly beyond a minimum.²¹ In choice theory, despite these protective duties, no positive rights for children can exist, as no rights for children exist, which means our children enter a world where moral thought concerning them is that the superior autonomous human beings merely have an obligation not to harm them. It should perhaps go without saying that we as a society have problems accepting this idea. Children have rights. These

¹⁸ Jones P (n 7) 35.

¹⁹ This is a similar argument to that of Onora O’Neill, not that she ever explicitly weds her ideas to choice theory, O’Neill O, ‘Children’s Rights and Children’s Lives’ (1988) 98 *Ethics* 445.

²⁰ Sumner LW (n 12) 204.

²¹ Archard D (n 2); Feinberg J, ‘The Child’s Right to an Open Future’ in Aiken W, and La Follette H, (ed), *Whose Child?* (Rowman & Littlefield 1980).

rights may not have always been recognised in law, such as the Roman Republic, yet as MacCormick states, “that only means that some or perhaps many legal systems have been morally deficient, which is scarcely a startling observation.”²² MacCormick seems to propose a blend of the two theories of rights, or what Van Bueren has interestingly termed a test match between them;²³ an interest theory conception for children, and accepting autonomy and a choice theory conception for adults.

This difference in the grounding of rights for adults and children has a basis in Feinberg’s work on the right to an open future, where certain rights are held exclusively by adults by virtue of their autonomy and certain rights are held exclusively by children by virtue of their dependency and need of protection.²⁴ The idea of a gradual shift from one to the other fits neatly with other established thoughts that one definition of rights for children will always be problematic because of the changing nature of childhood, which also fits with the common law idea of *Gillick* competency in the UK,²⁵ and that a search for a definitive point at which competency and capacity are gained in order to allow full autonomy is a ‘search for the Holy Grail.’²⁶ MacCormick does not explicitly state that this is his view, but in essence this is what it appears to be.

The presumption that people are the best judges of what is
good for them and of whether to have it or not is not and

²² MacCormick N, 'Children's Rights: a Test-Case for Theories of Right' in MacCormick N, (ed), *Legal Right and Social Democracy: Essays in Legal and Political Philosophy* (Clarendon Press 1984) 155.

²³ Van Bueren G (n 2) 6.

²⁴ Feinberg J (n 21) this could be an interesting discussion around the point at which children gain the right to refuse medical treatment, and also whether the State should force children to have vaccinations even against the parents wishes, however this lies beyond the scope of this thesis and will not be undertaken here.

²⁵ Glennon T, and Schwartz RG, 'Foreword: Looking Back, Looking Ahead: The Evolution Of Children's Rights' (1995) 68 *Temple Law Review* 1557, 1561; *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112 House of Lords.

²⁶ Chell B, 'Competency: What It Is, What It Is Not, and Why It Matters' in Morrison EE, and Furlong B, (ed), *Health Care Ethics: Critical Issues For The 21st Century* (Third edn, Jones and Bartlett Learning 2014) 129.

should not be extended to children, certainly not to young children. Neither in law nor in what I take to be sound morality can children's rights be regarded as carrying the option of waiver or enforcement by themselves or on their behalf.²⁷

Yet MacCormick finds it a "barely contestable assertion" to state that "every child has a right to be nurtured, cared for, and, if possible, loved, until such a time as he or she is capable of caring for himself or herself."²⁸ Freeman attacks such dichotomous debate in rights theory,²⁹ but despite his arguments, and that of MacCormick, any third option proposed comes down, not to a new theory, but to a gradual movement from one to the other; a movement from interest theory to choice theory as autonomy is increased.

One alternative rights theory that does not fit this pattern is proposed by Federle's power theory, and the belief that we should reconceive children as powerful rights-holders.³⁰ This theory misunderstands its own fundamental starting point and fails to acknowledge that in order for children to become powerful, they must be given power. This bestowal automatically betrays the very notion of Federle's idea as the establishment that can grant power, can also take it away. Merely stating that someone is powerful does not make it so, in fact often the reverse is true as Margaret Thatcher reportedly pointed out; "Being in power is like being a lady. If you have to remind people that you are, you aren't."³¹ Power is a very loose and difficult word to define and explain. Exactly why an entire group of people believe someone

²⁷ MacCormick N (n 22) 166.

²⁸ *ibid* 154-5.

²⁹ Freeman MDA, 'Taking Children's Rights More Seriously' (1992) 6 *International Journal of Law and the Family* 52, 66.

³⁰ Federle KH (n 3).

³¹ Gerodimos R, Scullion R, Lilleker DG, and Jackson D, 'Introduction to the media, political participation and empowerment' in Scullion R, Gerodimos, R., Jackson, D., and Lilleker, D. G. (ed), *The Media, Political Participation and Empowerment* (Routledge Research in Political Communication, Routledge 2013) 2; see also Maxwell J, 'The Law of E. F. Hutton: When the Real Leader Speaks, People Listen', *Ultimate Leadership: Maximize Your Potential and Empower Your Team* (Classic Leadership Collection, Thomas Nelson 2007).

is powerful and are willing to acknowledge that power is not easy to define or understand. For children, power is certainly the wrong term to use.

Federle argues that interest theory acknowledges the powerlessness of children,³² because the powerful decide and bestow rights based on others interests which undermines them. This may be true, but it is also an accurate representation and the only way to ensure rights for neonates and young children are guaranteed. A child can be said to have an interest in being heard and taken seriously; not so much a right to be powerful (as no-one has that right, especially based solely on their own interests). This substantial interest can justify a right. If Federle is right, she has again unintentionally admitted that grounding rights for children on interests may be the most accurate representation of children's rights currently, and merely stating they are or should be powerful will not change anything. My own view is that the dichotomy of interests and choice is unavoidable in current rights theory discussion, even when accepting a cross over. Some rights become wedded to choice theory and the exercise of control/freedom as autonomy is gained, yet some remain firmly grounded on an interest theory conception, which remains more dominant even in adult life.

The concept of unwaivable rights; rights of third party beneficiaries, under which a right can be held by one who will not benefit from the duty; and the issue of what a 'sufficient' interest is that will ground and justify a right, all show that interest theory is not without clear problems. Yet protecting sufficient interests is vital for children to have rights, and perhaps equally vital for protecting them in order to allow them to become autonomous moral agents. Freeman would seem to agree: "Children have

³² Federle KH (n 3) 1597-8; O'Neill O, *Constructions of Reason: Explorations of Kant's Practical Philosophy* (Cambridge University Press 1989) 202, argues however that children are naturally dependent on adults and not artificially. Therefore children will always be a vulnerable group and the only 'cure' is to grow up. This natural dependence will not disappear by any empowerment theory proposed. In a way it is a scientific argument that no matter what laws or philosophical theories may be proposed, nature will always play its part.

interests to protect before they develop wills to assert".³³ Yet the sufficient interests required by interest theory will be decided by adults, for example, what interests are sufficient to bestow any legal and tangible rights onto a child will be decided by the legislature. So even on this theory of rights it is accepted that adults decide the rights for children. This is the same for all theories, rights and laws, despite authors suggesting their approach is better for children (the capabilities approach for example which suggests it is far more accommodating to the rights of the child and those with severe disabilities than *traditional* social contract theories).³⁴ They are all still theories written by adults which merely take children into consideration. The approach, reasoning and moral justification may differ, but all such ideas come down to adults dictating what rights they think children should have.

2.1.2 Exercising Children's Rights in Practice

After this discussion on the theory of children's rights, the difficulties and challenges of realising, exercising and more specifically enforcing these rights needs to be considered against the wider literature to highlight the problem and also accept the limitations of what is discussed in this work. The importance of judicial enforcement for realisation of children's rights is a well-established argument given children's lack of involvement in the democratic process and therefore inability to enforce their rights from a counter-majoritarian perspective.³⁵ This idea underlies the focus on the judicial process and importance of the adjudication of economic, social and cultural rights throughout this thesis, which will be discussed in extensive detail in chapter

³³ Freeman MDA (n 29) 58.

³⁴ Dixon R, and Nussbaum MC, 'Children's Rights and a Capabilities Approach: The Question of Special Priority' (2012) 97 Cornell Law Review 549, 563.

³⁵ Nolan A, *Children's Socio-Economic Rights, Democracy and the Courts* (Human Rights Law in Perspective, Hart Publishing 2011) 17, 38, 109.

three. However, some space should be given to the issues around whether such cases can be brought and the problems facing the legal standing of children.

The Committee on the Rights of the Child has accepted these challenges for children stating that their “special and dependent status creates real difficulties for them in pursuing remedies for breaches of their rights”.³⁶ There are a variety of barriers to children accessing and utilising the legal system and initiating legal proceedings. A child may not have an appropriate adult to bring a case for them, or such an adult may not believe it is in a child’s interests to litigate.³⁷ The difficulties of children employing the legal process itself, is evidenced by the lack of ESC rights cases that have been initiated by children. However, as Nolan suggests, whilst it is important not to disregard these difficulties and problems, there is no easy solution for all children. In a similar way to her discussion, this thesis focuses on the implementation, enforcement and appropriate adjudication of such rights and therefore it will also be assumed that these obstacles to initiating cases can be overcome through a variety of methods, for example, Nolan has commented that existing cases show this obstacle can be overcome, with NGOs that are willing to take up such cases providing the strongest course of action.³⁸

A promising example comes from the Philippines where the Supreme Court very quickly accepted the *locus standi* of minors when intergenerational justice was threatened.³⁹ The minors were challenging the right to a balanced and healthy ecology as protected in the Philippine Constitution.⁴⁰ The Court dealt briefly with the children’s standing to sue and quickly found “no difficulty in ruling that they can, for

³⁶ Committee on the Rights of the Child, *General Comment No 5* on General Measures of Implementation of the Convention on the Rights of the Child (arts 4, 42 and 44 para 6), UN Doc CRC/GC/2003/5 (2004) para 24.

³⁷ Nolan A (n 35) 223

³⁸ Nolan A (n 35) 224.

³⁹ *Oposa (minors) et al. v. Factoran (in his capacity as Secretary of the Department of Environment and Natural Resources) et al.* GR No. 101083 (1993) 224 SCRA 792.

⁴⁰ *The 1987 Constitution of the Republic of the Philippines. Article 2, Section 16.*

themselves, for others of their generation and for the succeeding generations, file a class suit.”⁴¹ Whilst the case led to little or no practical impact,⁴² opinions differ on the effect of the court accepting *locus standi* of the minors. Gatmaytan argues that the court did not create the precedent that has been suggested, partly because in the Philippines the rules on standing are less stringent, and partly because the brief comments made by the court amount to *obiter dictum* as they were not an important aspect of the decision.⁴³ However, it is also argued that the intergenerational nature of their comments sets new precedent in applying constitutional rights to those yet to be born.⁴⁴ The standing for future generations is not something to consider, however the ease with which the court categorically stated that children had standing to bring a class suit that would apply to them and all of their generation is something that any child’s rights’ advocate would support. Ensuring children have *locus standi* before a court is not simply a word or phrase that is meaningless. It is an action the courts can ensure. This idea, combined with Public-Interest Litigation could lead to many more child’s rights cases determining whether or not a government is ensuring its constitutional and international legal obligations.

As children cannot effectuate their rights through the democratic process, the courts importance is amplified.⁴⁵ However, available remedies must be accessible and widely published, and during any proceedings the wishes of the child must be

⁴¹ *Oposa (minors) et al. v. Factoran* (n 39) 802.

⁴² Gatmaytan DB, 'The Illusion of Intergenerational Equity: *Oposa v. Factoran* as Pyrrhic Victory' (2003) 15 The Georgetown International Environmental Law Review 457, 467; see also Manguiat MSZ, and Yu III VPB, 'Maximizing the Value of *Oposa v. Factoran*' (2003) 15 The Georgetown International Environmental Law Review 487, 488.

⁴³ Gatmaytan DB (n 142) 471.

⁴⁴ Manguiat MSZ, and Yu III VPB (n 42) 493.

⁴⁵ This is the so-called counter-majoritarian view against judicial review and enforcement of rights perhaps most prominently espoused by Jeremy Waldron. However the argument that the democratic process is the best place to push for rights implementation and ensures the views of the majority govern, whilst not without its critics even for adults (such as a domination of the minority) is not applicable to children who have no say in the democratic process. In this way there can be no assurance of consideration of their rights and as such, the courts provide the most important role in ensuring the State fulfils its obligations to children.

paramount.⁴⁶ As a child generally cannot individually bring claims and actions must be done on their behalf, the importance of class actions by powerful NGOs cannot be over-stated. Whilst the courts are just one part of giving effect to a child's right to healthcare, they are still a powerful tool. However it is important to consider other options as well. "[A]dvocates for children cannot rely solely on the courts to protect the rights of their clients."⁴⁷ This will be discussed in chapter six. Now discussion will move on to the implementation of current international law and the systems presently in place to analyse whether or not their rights can be delivered without court intervention.

In particular, this chapter will now discuss if a child's right to health might be found in international law. Having established the instruments which enshrine a child's right to health the discourse will move onto what this means and how this translates in terms of enforcement and implementation. This discussion is important in order to demonstrate if the rights are tangible guarantees or some idealistic goals without any practical effort in place to achieve them.⁴⁸ This debate also looks at regional human rights law and strategies, with particular focus on Europe, widely considered the most successful implementer of human rights.⁴⁹

⁴⁶ Spronk-van der Meer SI, *The Right to Health of the Child: An analytical exploration of the international normative framework* (Intersentia, 2014) 249.

⁴⁷ Glennon T, and Schwartz RG (n 25) 1568.

⁴⁸ Burman E, 'Local, Global or Globalized?: Child Development and International Child Rights Legislation' (1996) 3 *Childhood* 45, 50; see also Freeman M, 'The Limits of Children's Rights' in Freeman M, and Veerman P (ed), *The Ideologies of Children's Rights*, vol 23 (Martinus Nijhoff Publishers 1992) 71-80; see also Freeman M, 'Laws, Conventions and Rights' in Freeman M (ed), *The Moral Status of Children: Essays on the Rights of the Child* (Martinus Nijhoff Publishers 1997) 47-62; see also Bates E, 'The United Kingdom and the International Covenant on Economic, Social and Cultural Rights' in Baderin M, and McCorquodale, R. (ed), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007).

⁴⁹ O'Boyle M, 'Reflections on the Effectiveness of the European System for the Protection of Human Rights' in Bayefsky AF (ed), *The UN Human Rights Treaty System in the 21st Century* (Kluwer Law International 2000); Gardbaum S, 'Human Rights as International Constitutional Rights' (2008) 19 *European Journal of International Law* 749; see also Green A, 'A philosophical taxonomy of European human rights law' (2012) 1 *European Human Rights Law Review* 71; Smith RKM, *Textbook on International Human Rights* (Sixth edn, Oxford University Press 2014) 115.

One of the reasons for the focus on international law rather than domestic law is the attempt to find external pressure and possible redress from the international community for any violations. As seen in the first chapter, the political internal measures to ensure a child's right to healthcare are not working in many cases, even in the richest country in the world. International law should help ensure the universality of a child's right to healthcare and the obligation of all States to ensure this right (as established in chapter one). Another reason for looking at human rights law as opposed to small projects by non-governmental organisations (NGOs) is sustainability and the hope of long-term solutions.⁵⁰ The ultimate aim of an NGO is to make itself redundant.⁵¹

It will be shown that various human rights implementation mechanisms differ in their strategies and outcome, and that is why there is a greater focus on the comparatively successful European model.⁵² If the aim of the thesis is to conclude with a strategy for successful global implementation of a child's right to healthcare, then it would seem that learning from the most successful regional implementer would be a worthwhile measure. First, the scope of the right to healthcare in international law will be considered.

⁵⁰ Tripathi V, Hoodbhoy MO, and Rosenthal M, 'Promoting Human Rights in Public Health Programs: Lessons Learned From HealthRight International' in Beracochea E, Weinstein C, and Evans DP (ed), *Rights-Based Approaches to Public Health* (Springer Publishing Company 2011) 262.

⁵¹ Wolff J, *The Human Right to Health* (Amnesty International Global Ethics Series, First edn, W. W. Norton & Company, Inc 2012) 36. However, it will be shown that pressure and redress in international law are lacking in many cases, reflecting the widely acknowledged problem that the strategies are well known as 'lacking teeth'.

⁵² Freeman M, 'The Limits of Children's Rights' (n 48); see also Burman E (n 48) 50; see also Mann J, Gostin L, Gruskin S, Brennan T, Lazzarini Z, and Fineberg HV, 'Health and Human Rights' (1994) 1 *Health and Human Rights* 7, 10; Reinbold GW, 'Realising Young Children's Right to Health Under the Convention on the Rights of the Child: The Promise - and the Reality in Bangladesh and Kenya' (2014) 22 *International Journal of Children's Rights* 1.

2.2 International Law

2.2.1 Right to Health in International Law

To begin this section, the question of where a right to healthcare can be found in international law will be addressed. This is a broad search for the right in international law because the enjoyment of the highest attainable standard of health is not meant to be a right exclusively for children.⁵³ After this, discussion will move on to how effect is given to the right where it can be found, specifically treaties, the major sources of international legal authority.⁵⁴ They also help to define the content of the right and impose duties to assure healthcare services.⁵⁵ As early as July 1946, and implemented in 1948, the United Nations established the World Health Organization. The WHO constitution (1946) first formulated the concept of a right to health stating that: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”⁵⁶ The importance of establishing an international position on a right to health was even supported by then President of the United States Harry Truman who stated “it [is] necessary to

⁵³ Doek JE, 'Children and Their Right to Enjoy Health: A Brief Report on the Monitoring Activities of the Committee on the Rights of the Child' (2001) 5 Health and Human Rights 155, 156.

⁵⁴ Kinney ED, 'Recognition of the International Human Right to Health and Health Care in the United States' (2008) 60 Rutgers Law Review 335, 337.

⁵⁵ *ibid* 337.

⁵⁶ *Constitution of the World Health Organization* (1946) preamble; This is after defining health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, for in depth discussion as to why this very broad definition may not be appropriate see Callahan D, 'The WHO Definition of 'Health' (1973) 1 The Hastings Center Studies 77; see also Daniels N, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008) 37; see also da Costa Leite Borges D, 'Making sense of human rights in the context of European Union health-care policy: individualist and communitarian views' (2011) 7 International Journal of Law in Context 335, 337; see also Hervey TK, and McHale JV, 'Law, health and the European Union' (2005) 25 Legal Studies 228, 229; see also Tobin J, *The Right to Health in International Law* (Oxford University Press 2011) 122.

develop strong health services in every country, which must be coordinated through international action.”⁵⁷

Then, in 1948, Article 25 of the Universal Declaration of Human Rights (UDHR) was drafted which states that; “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and his family, including . . . medical care”.⁵⁸ There is no further definition of this right offered in the declaration or international law until the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR).⁵⁹ The UDHR was split into two separate covenants, one being the ICESCR, and the other being the International Covenant on Civil and Political Rights (ICCPR),⁶⁰ adopted at the same time. Both these Covenants elaborate on the rights within the UDHR⁶¹ and collectively these three human rights instruments are known as the International Bill of Rights.⁶²

Absent elaboration in the UDHR, the ICESCR is the most important amongst these for the general right to health. Article 12 of the ICESCR is clear in making healthcare a human right in international law stating:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

⁵⁷ Wolff J (n 51) 5; Truman stated this at the first International Health Conference in New York in 1946, showing the initial determination of the US to ratify the conventions including a right to health with support from Truman’s predecessor Franklin D. Roosevelt and later Eleanor Roosevelt, heavily involved in the drafting of the UDHR; see Kasper J, and Wise PH, ‘The Relevance of the United Nations Convention on the Rights of the Child for United States Domestic Policy: Welfare Reform and Children in Immigrant Families’ (2001) 5 Health and Human Rights 64.

⁵⁸ *The Universal Declaration of Human Rights* (1948), Article 25.

⁵⁹ Kinney ED (n 54) 339.

⁶⁰ *International Covenant on Civil and Political Rights* (1966).

⁶¹ Mann J, and others (n 52) 10.

⁶² *ibid*; Easley CE, Marks, S. P., and Morgan Jr, R. E. (n 6) 1923; Darrow M, *Between Light and Shadow: The World Bank, The International Monetary Fund and International Human Rights Law* (Studies in International Law, Hart Publishing 2003) 5; Kinney ED (n 54) 339; Smith RKM (n 49) 30 and 37.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of *infant mortality and for the healthy development of the child* .

. .

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.⁶³

Such wording clearly envisages the establishment of a system of universal coverage in healthcare, and 12.2(a) focuses on the importance of children's healthcare. Assuring everyone can access medical services may not by itself appear to require the State to fund healthcare. However, part of the right to access medical services is that everyone must have the ability to access medical services, financially and geographically for example. If there is a right to healthcare then there must be a right to access that care, otherwise the right is purely formal and does not exist, or to put another way, the very concept of having a right entails access to the subject of the right.⁶⁴ Brassington rightly states:

There is no medical equivalent of DIY. . . . If you have a right to healthcare, and that healthcare requires private provision, and if you lack the means to buy private insurance, then your right turns out, at most, to have been purely formal. But a right that is purely formal is no such thing: for all the good that it will do them, we might as well tell people that they have a right to walk to Venus.⁶⁵

A duty is the natural correlative of a right.⁶⁶ The right of everyone to access healthcare, in practice, requires the State to ensure everyone can afford necessary care, or to make healthcare free for those who cannot afford it. The Committee on

⁶³ *International Covenant on Economic, Social and Cultural Rights* (1966), Article 12 – emphasis added.

⁶⁴ Leary VA, 'The Right to Health in International Human Rights Law' (1994) 1 *Health and Human Rights* 25, 38; see also Brassington I, *Public Health and Globalisation: Why a National Health Service Is Morally Indefensible* (Societas, Imprint Academic 2007) 29.

⁶⁵ Brassington I (n 64) 29.

⁶⁶ Hohfeld WC, *Fundamental legal conceptions as applied in judicial reasoning: and other legal essays* (Yale University Press 1919).

Economic, Social and Cultural Rights (CESCR) has also made this clear when interpreting Article 9 and 26(1) of the ICESCR which provide for a child's right to social insurance, to include protection from unaffordable healthcare.⁶⁷ Furthermore, all rights are under a non-discrimination principle, which includes economic status, and as such a solely market-based approach should be rejected and State assurance is necessary.⁶⁸ If health services do not consider financial barriers, access to such care is restricted and intentional, or unintentional, discrimination occurs.⁶⁹ The content of the right to health is outlined even more specifically in General Comment 14, published by the CESCR in 2000.⁷⁰ This General Comment also acknowledges the financial problems with a demand for "equality of opportunity for people to enjoy the highest attainable level of health",⁷¹ obligating the State to provide an immediate guarantee that there will be no discrimination in exercising the right to health.⁷² As seen in chapter one, this is not always the case and this chapter looks at the current measures to prevent such violation of the right to health in section 2.3.

Furthermore the general right to health is found in the Declaration of Alma-Ata (1978) written by the International Conference on Primary Health Care.⁷³ The declaration espouses some specific health measures to be taken in achieving primary health care such as the importance of immunisation against major diseases

⁶⁷ Committee on Economic Social and Cultural Rights, *General Comment No. 19: The Right to Social Security (E/C.12/GC/19)* (2008) (hereafter General Comment 19)13; Reinbold GW (n 52) 12.

⁶⁸ Leary VA (n 64) 37.

⁶⁹ Mann J, and others (n 52) 10.

⁷⁰ Committee on Economic, Social and Cultural Rights. *General Comment No. 14 - the Right to the Highest Attainable Standard of Health* (2000) Vol. UN doc.E/C.12/2000/4 (hereafter General Comment 14).

⁷¹ *ibid* 8.

⁷² da Costa Leite Borges D (n 56) 338; see also Yamin AE, 'Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care' (2008) 10 *Health and Human Rights* 45, 52.

⁷³ International Conference On Primary Health Care, *Declaration of Alma-Ata* (1978).

and prevention of ill health.⁷⁴ This Declaration is mentioned in General Comment 14 as its recommended measures forming part of the minimum core of the right to health.⁷⁵ The declaration also highlighted the gross inequality between developed and developing countries which is unacceptable and called for a reduction of this gap (an argument further discussed in more detail in chapter six).⁷⁶ Such a reduction relies on international cooperation which is required in international law under Article 2(1) of ICESCR.⁷⁷

Implementation strategies for the ICESCR will be discussed more in 2.3 but further recommendations come from another important document on these rights, the 1987 Limburg Principles⁷⁸ which specifically states that States Parties use all appropriate measures, including judicial, to fulfil their Covenant obligations.⁷⁹ These principles are non-binding and are designed solely for interpretative purposes.⁸⁰ The implementation of judicial measures referred to here will be further discussed in the next chapter as this seems an important part of the principles as paragraph 19 reiterates: “States Parties shall provide for effective remedies including, where appropriate, judicial remedies.”⁸¹ I contend that in being separate from the legislature, which can prove slow and unreliable, judicial remedies can play a vital role in achieving the full realisation of a child’s right to healthcare. Some argue further that courts have a duty to intervene where the executive and legislative

⁷⁴ *ibid* Art VII 3.

⁷⁵ General Comment 14, 43.

⁷⁶ International Conference On Primary Health Care, *Declaration of Alma-Ata* (1978) Art. II and III.

⁷⁷ *International Covenant on Economic, Social and Cultural Rights* (1966), Article 2 (1).

⁷⁸ Committee on Economic, Social and Cultural Rights. *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights* (1987) UN Document E/CN.4/1987/17 (hereafter *The Limburg Principles*).

⁷⁹ *ibid* 17.

⁸⁰ Van Bueren G (n 2) 296.

⁸¹ *The Limburg Principles* 19.

branches have comprehensively failed.⁸² It is suggested that judicial remedies are also part of the obligation to fulfil the right derived from General Comment 14,⁸³ with paragraph 9 specifically mentioning effective judicial remedies.⁸⁴ How these rights manifest in practice and the issues with their enforcement will be explored below.

2.2.2 Children's Rights in International Law

Adopting a specific human rights treaty for children began as early as 1924 with the adoption of the Declaration of the Rights of the Child (Geneva Declaration) by the League of Nations and subsequently the United Nations in 1946.⁸⁵ This was later replaced in 1959 by a second draft declaration,⁸⁶ however it was not until 40 years later that a legally binding⁸⁷ convention was established. This has its origins in Article 25 of the UDHR⁸⁸ and the 1959 Declaration and is now the most important international document for children's rights more generally: the Convention on the Rights of the Child (CRC).⁸⁹ This convention was adopted by the UN General Assembly in 1989, and took less than a year to come into force in September 1990, showing its popularity given the 10 years the ICESCR took. No human rights treaty in history has entered in to force more rapidly than the CRC, or had more ratifications.⁹⁰ It is the most universally accepted, legally binding document in the

⁸² Bates E (n 48) 291; see also Ghai Y, and Cottrell J, (ed), *Economic, Social and Cultural Rights in Practice: The Role of the Judges in Implementing Economic, Social and Cultural Rights* (Interights 2004).

⁸³ da Costa Leite Borges D (n 56) 339.

⁸⁴ General Comment 14, 9.

⁸⁵ Pink R, 'Child Rights, Right to Water and Sanitation, and Human Security' (2012) 14 Health and Human Rights 1, 5.

⁸⁶ UN General Assembly Resolution 1386 (XIV), *Declaration of the Rights of the Child* (1959), which mentions adequate medical services in Article 4 as well as specific rights to pre and post-natal care, and growth and development in health; see also *Convention on the Rights of the Child*. 1989 (preamble).

⁸⁷ Burman E (n 48) 50.

⁸⁸ Kasper J, and Wise PH (n 57) 66.

⁸⁹ *Convention on the Rights of the Child* 1989.

⁹⁰ Burman E (n 48) 51.

world.⁹¹ At present, only two UN member States have not ratified the CRC. South Sudan, the newest member State, becoming a member in July 2011, passed legislation in November 2013 approving ratification. On the 23rd January 2015 it became the 194th country to ratify the CRC.⁹² The nations to not yet ratify are Somalia and the United States; this despite the heavy involvement and influence of the US in the drafting of the Convention.⁹³ The US also joined the unanimous vote by the General Assembly for the Convention.⁹⁴ The influence of America in the early years post World War II, with the Marshall Plan and establishment of the United Nations is lamented as it no longer acts with such former maturity on the world stage.⁹⁵

The CRC is the first legally binding international instrument that recognises both civil and political rights, as well as economic, social and cultural rights.⁹⁶ The CRC clearly establishes a right to healthcare in Article 24⁹⁷ which explicitly states the right

⁹¹ Kasper J, and Wise PH (n 57) 64.

⁹² UNICEF: South Sudan National Legislative Assembly passes the bill for Ratification of UN Convention on the Rights of the Child available from <http://www.unicef.org/southsudan/media_ratification-CRC.html>last viewed 23/09/2015; see also UN Treaty Collection <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en>last viewed 23/09/2015 and UN Member States <<http://www.un.org/en/members/index.shtml>>last viewed 23/09/2015.

⁹³ Burman E (n 48) 51.

⁹⁴ Kasper J, and Wise PH (n 57) 66.

⁹⁵ Ranney JT, 'How World Federalism Will Likely Come Into Existence' in D'Souza A, and D'Souza C (ed), *World Constitutionalism* (Cambridge Scholars Publishing 2007) 106.

⁹⁶ Tomás C, 'Childhood and Rights: Reflections on the UN Convention on the Rights of the Child' (2008) *Childhoods Today: An online journal for childhood studies* <<http://www.childhoodstoday.org/article.php?id=19>>.

⁹⁷ The full words of the article are: 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported

to access health care services as well as more specific measures such as reducing child mortality, preventive health care services, and international cooperation to aid developing countries achieve fulfilment of the right.

This important, detailed article clearly explains what is expected of the State in fulfilling the right of the child to healthcare. It unequivocally envisages universal access to healthcare for children and the government's responsibility to ensure it.⁹⁸ It is the most elaborate and specific article in international law for a right to healthcare.⁹⁹ The indicators discussed in chapter one are clearly part of the aim to protect children's health, with mortality reduction, preventive health care, and post-natal care, being specifically mentioned in article 24, with the reference to primary healthcare being one of the most distinguishing factors.¹⁰⁰ A child's right to healthcare is therefore clearly established in international law, but the important documents defining the right do not stop there. General Comments 14 of ICESCR¹⁰¹ and 15 of the CRC,¹⁰² further define the right and its implementation strategies and will be discussed more in 2.3 when looking at what establishing the right to health in international law actually means. It has been shown that the right to health occurs in many international instruments,¹⁰³ showing its importance and inescapable establishment; it cannot be said that there is no right to health in international law.

in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; (f) To develop preventive health care, guidance for parents and family planning education and services. 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. 4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

⁹⁸ Kasper J, and Wise PH (n 57) 80.

⁹⁹ Doek JE (n 53) 156; Spronk-van der Meer SI (n 46) 44.

¹⁰⁰ Van Bueren G (n 2) 297-298.

¹⁰¹ General Comment 14.

¹⁰² Committee on the Rights of the Child, *General Comment No 15* on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) CRC/C/GC/15 (2013).

¹⁰³ The right to health is recognised in; Article. 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR); art.25 of the Universal Declaration on Human Rights

2.3 Interpretation and Enforcement

2.3.1 International Human Rights Law

As mentioned above, the most important instruments for a child's right to healthcare within international human rights law are the UDHR, the ICESCR and the CRC. The next step is to establish what placing the right to health in these instruments means; whether it has been a futile exercise of merely putting words on paper, or has had a physical and pragmatic impact. In essence this requires a closer analysis of what the interpretation of the right is, what is expected, and how this is monitored and enforced to guarantee State compliance. It is important at the outset to note that the right to health is not a right to be healthy.¹⁰⁴ It is a right that the State does what it can to prevent ill health arising, and in the event of ill health, put in place measures that will return someone to a healthy state. Such legal obligations do not arise from declarations however, hence the ICCPR and ICESCR,¹⁰⁵ and a State must actively chose to ratify the covenant.¹⁰⁶ There is no requirement to do so. Even if a State does, often they put forward reservations declaring which parts of the treaty they agree to be bound by as permitted by the Vienna Convention on the Law of Treaties.¹⁰⁷ For dualist States, the legislature must vote to make the covenant/convention/treaty binding upon the country, which in turn creates specific obligations upon the country to realise the rights within the covenant.¹⁰⁸ For monist States, the only requirement is for the State to become a signatory to the convention

(UDHR); art.5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (CERD); arts 11.1(f) and 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) and art.24 of the Convention on the Rights of the child (CRC); see also Tobin J (n 56) 15, 18 and 43.

¹⁰⁴ General Comment 14, 8.

¹⁰⁵ Kinney ED (n 54) 339; Smith RKM (n 49) 37-38.

¹⁰⁶ Mann J, and others (n 52).

¹⁰⁷ United Nations, *Vienna Convention on the Law of Treaties* (1969) 19.

¹⁰⁸ Cassese A, *International Law* (Oxford University Press, 2nd edn, 2005) 213-216.

and then they are bound by it as soon as it becomes international law with the necessary number of ratifications.¹⁰⁹ This is the same for the CRC which is incorporated in various ways into domestic law, as equal to either the constitution, or ordinary legislation or in between them dependent on the country.¹¹⁰ For now, discussion examines some key aspects of interpretation of the right to health, the nature of progressive realisation and the specific content expected,¹¹¹ before discussing the enforcement strategies used to try and ensure State compliance.

2.3.1.1 *Progressive Realisation*

One vitally important point to be made about what the right to health and healthcare in these international conventions means is the principle of progressive realisation. This is a principle to which all economic, social and cultural (ESC) rights are subject¹¹² and so circumvents certain criticism directed at ESC rights that they violate the logical, ethical and rule of law principle 'ought implies can', which means there cannot be a right to something that cannot be done.¹¹³ Whilst resources are

¹⁰⁹ Ibid; see also Drake JG, 'Monism and Dualism in the Theory of International Law' in Paulson SL, and Paulson BL, (ed), *Normativity and Norms: Critical Perspectives on Kelsenian Themes* (Oxford University Press 1999) 537-552; Cassese and Drake discuss monism and dualism in the context of international law theory. It is argued that there are three main schools of thought; a) monism b) dualism and c) a monism with the supremacy of municipal law (according to Cassese) which leads to international law not being considered real law, which is the third school according to Drake. States have chosen their concepts based on whether they believe international law and municipal law are concomitant and arise out of the same juridical reality (monism) or if they hold that they are distinct normative views (dualism).

¹¹⁰ Reinbold GW (n 52) 22.

¹¹¹ For an in depth discussion see Tobin J (n 56) who spends 5 chapters discussing the interpretation of the right, showing its complexity and that a thoroughly in depth discussion and analysis is beyond the scope of this thesis.

¹¹² *International Covenant on Economic, Social and Cultural Rights* (1966), Article 2.

¹¹³ Kant I, *The Critique of Pure Reason* (Electronic Classics Series 1787) 323; see also Rawls J, *A Theory of Justice: Revised Edition* (Oxford University Press 1999) 208; see also Brassington I (n 64) 79; see also Craven M, 'The Violence of Dispossession: Extra-Territoriality and Economic, Social, and Cultural Rights' in Baderin M, and McCorquodale R, (ed), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007) 81;

the 'bedrock' of any health care system,¹¹⁴ "the idea of an ought or of duty indicates a possible action . . . This action must certainly be possible under physical conditions, if it is prescribed by the moral imperative ought".¹¹⁵ Critics rightly point out the difficulty many States have to fulfil ESC rights, giving rise to questions as to whether they are more idealistic goals.¹¹⁶ This proved a drafting challenge for many international treaties that include ESC rights and critics have wrongly suggested an infringement of 'ought' implies 'can'.¹¹⁷ However, the principle of progressive realisation means that there is no infringement, so the criticism is not upheld: "[S]ince *ought* is usually taken to imply *can*, it would follow that we are under an obligation to satisfy only those claims that we reasonably can, given other obligations that we might have."¹¹⁸ The CESCR accepts this, providing that the inability to fulfil the right straight away because of a lack of resources is satisfactory, yet this does not mean the right does not exist or is meaningless.¹¹⁹ Article 2 (1) of the ICESCR explains the concept of progressive realisation and the extent of maximum available resources.¹²⁰ This allows for understanding of resource scarcity, but progressive steps must still be taken with a view to achieving full realisation. Interestingly, the CRC does not express progressive realisation in an all-

Wolff J (n 51) whose book is an exercise in cautious idealism and the ought implies can doctrine in relation to the right to health.

¹¹⁴ Roemer R, 'The Right to Health Care - Gains and Gaps' (1988) 78 *American Journal of Public Health* 241, 243.

¹¹⁵ Kant I (n 113) 323; see also Brassington I (n 64) 79; see also Craven M (n 113) 81.

¹¹⁶ Dennis MJ, and Stewart DP, 'Justiciability of Economic, Social, and Cultural Rights: Should There be an International Complaints Mechanism to Adjudicate Rights to Food, Water, Housing, and Health?' (2004) 98 *American Journal of International Law* 462, 463-464.

¹¹⁷ Reinbold GW (n 52) 14; see also Cranston M, 'Human Rights, Real and Supposed' in Raphael DD, (ed), *Political Theory and the Rights of Man* (Macmillan 1967) 43, 50-51; for a response that differs from highlighting progressive realisation and instead focuses on the need to redistribute resources see Waldron J, 'Socioeconomic Rights and Theories of Justice' (2010) Public Law and Legal Theory Research Paper Series, Paper No 10-79.

¹¹⁸ Brassington I (n 64) 79.

¹¹⁹ Tobin J (n 56) 69.

¹²⁰ *International Covenant on Economic, Social and Cultural Rights* (1966), Article 2 (1).

"Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

encompassing way for ESC rights like the ICESCR does. Instead the CRC specifically provides for progressive realisation of two rights; education and health. Thus what the right to health means, what is attainable and expected, is relative.¹²¹ This progressive realisation is viewed as a “flexible device, reflecting the realities of the world”¹²² and the Committee, which oversees the implementation of the Covenant, also severely restricts any deliberately retrogressive measures.¹²³ Progressive realisation therefore does not mean that States with limited resources have no obligations.¹²⁴ Thus the criticism that ESC rights are idealistic and cannot be achieved is not accepted.

Another criticism based on progressive realisation is the difference between civil and political rights which can be implemented immediately and universally because they are not resource dependent.¹²⁵ Civil and political rights differ in some ways from ESC rights in that the latter set of rights tended to find their way into constitutions and conventions later. This has given rise to the terms first generation and second generation rights applied to civil and political and then ESC respectively.¹²⁶ Nevertheless, it is contended here that the rights do not differ in the positive and negative ways some have argued.¹²⁷ The first generation, civil and political, rights are those that should be recognised immediately and those which

¹²¹ Tobin J (n 56) 123; Spronk-van der Meer SI (n 46) 47.

¹²² Committee on Economic, Social and Cultural Rights *General Comment No. 3 - the Nature of States Parties Obligations* (1990) (hereafter General Comment 3).

¹²³ *ibid.*

¹²⁴ Leary VA (n 64) 46.

¹²⁵ Cranston M (n 117).

¹²⁶ Brown C, 'Universal Human Rights: A critique' (1997) 1 *The International Journal of Human Rights* 41, 53.

¹²⁷ Yamin AE (n 72) 52; McHale JV, 'Fundamental rights and health care' in Mossialos E, Permanand G, Baeten R, and Herve T (ed), *Health Systems Governance in Europe* (Cambridge University Press 2010) 284; Möller K, 'From constitutional to human rights: On the moral structure of international human rights' (2014) 3 *Global Constitutionalism* 373, 378 points out that rights imposing only negative obligations is the dominant narrative of philosophy; see also Kalantry S, Getgen JE, and Koh SA, 'Enhancing Enforcement of Economic, Social, and Cultural Rights Using Indicators: A Focus on the Right to Education in the ICESCR' (2010) 32 *Human Rights Quarterly* 253, 255 where it is argued that the distinction between civil and political, and ESC rights is collapsing.

evolved earlier, and include the right to life and fair trial. The second generation, ESC rights, evolved later and are less immediately realisable, particularly in developing States.¹²⁸ However, Van Bueren disagrees with this generational categorising as a historical inaccuracy because as early as 1924 with the first Declaration of the Rights of the Child ESC rights were recognised.¹²⁹ It has also been suggested that positive, ESC, rights involve expenditure of public money whereas negative rights do not. Many authors have pointed out the fallacy of this argument.¹³⁰ Tobin rightly points out that these rights are not implemented without cost and that this argument has been repeatedly discussed and defeated in the literature.¹³¹ He points out that the right to life requires the creation of a criminal justice system in order to protect individuals and hold perpetrators to account, which clearly involves large resources.¹³² Wolf makes the same point suggesting the real reason for the objections between them is ideological, not a practical lack of resources,¹³³ and Möller points out that the example of South Africa shows that the trend has shifted, and rights no longer give rise to negative obligations exclusively.¹³⁴ However there may be a reason for the vagueness of ESC rights, but this will be addressed in the next section.

The economic differences between developed and developing States means that some States will fail to realise even the minimum core of ESC rights, which Craven points out is an “apparent disjunction”¹³⁵ between proclaimed rights and the conditions required to meet them. This is why Tobin also highlights the phrase ‘through international assistance and co-operation’ in ICESCR as designed to

¹²⁸ Smith RKM (n 49) 45.

¹²⁹ Van Bueren G (n 2) 8.

¹³⁰ Wolff J (n 51) 14; Tobin J (n 56).

¹³¹ Tobin J (n 56) 64, see footnote 107; see also Yamin AE (n 72) 52.

¹³² Tobin J (n 56) 64.

¹³³ Wolff J (n 51) 14.

¹³⁴ Möller K (n 127) 379.

¹³⁵ Craven M (n 113) 83.

assuage the economic differences.¹³⁶ The phrase is a clear anticipation of help from developed States in realising the right to health in developing ones, but can equally raise the question of who is responsible for meeting the right.¹³⁷ It is acknowledged that the poorest countries cannot succeed in the realisation of these rights on their own.¹³⁸ Hammonds and Ooms argue that such assistance is legally binding on the high income countries that have ratified the conventions and that are also members of the World Bank and IMF.¹³⁹ Craven argues that a focus on the international environment shifts the discussion away from problems of resource limitations to a much needed question of distribution and economic reform.¹⁴⁰ This is all part of a necessary economic redistribution that will be discussed further in 6.1.

These measures of progressive realisation and international assistance are not restricted to the ICESCR but also find a place in Article 24 (4) of the CRC which reads:

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.¹⁴¹

This could not be clearer in establishing the measure of progressive realisation and international assistance from developed States and so criticism levelled at ESC rights and the right to health because of resources, or lack thereof, is unfounded

¹³⁶ Tobin (n 56) 69.

¹³⁷ Wolff J (n 51) 12.

¹³⁸ Horton R, 'The coming decade for global action on child health' (2006) 367 *The Lancet* 3, 4.

¹³⁹ Hammonds R, and Ooms G, 'World Bank Policies and the Obligation of Its Members to Respect, Protect and Fulfill the Right to Health' (2004) 8 *Health and Human Rights* 27; Hunt also reiterates this responsibility of developed nations, see Hunt P, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (2004) United Nations General Assembly, Contract No.: A/59/422; Yamin AE (n 72) 54; see also Ooms G, and Hammonds R, 'Taking up Daniel's challenge: The case for global health justice' (2010) 12 *Health and Human Rights* 29.

¹⁴⁰ Craven M (n 113) 86; see also Yamin AE (n 72) 55.

¹⁴¹ *Convention on the Rights of the Child* (1989) Article 24 (4).

and misconceived.¹⁴² There is a clear obligation on the world's richest nations to provide funds to the poorest so as to aid them in ensuring ESC rights, including a child's right to healthcare where it is afforded explicit mention. It might be thought that such financial help would cost far too much and be unsustainable, yet statistics suggest only an extra US\$50 billion a year is needed to ensure a minimum standard of healthcare in the world's poorest nations, which is 0.1% GDP of the 75 high income countries as defined by the World Bank.¹⁴³ The vast majority of these countries are also parties to the CRC, with the US as the only notable absentee, and thus they have ratified and accepted the assistance obligation clearly established in Article 24 (4). Craven argues that whilst the obligation is clearly implied to be of an external and international nature, it does not seem to have developed beyond participating in international humanitarian activity.¹⁴⁴ There will be further discussion of economic redistribution in 6.1, showing the obligation and ability of the richest countries to help ensure this right, but for now discussion continues on what these rights in international law actually mean by looking at the expected content of a right to health.

2.3.1.2 Content of the Right

Another concern with ESC rights and the right to health is that the "substantive meaning of the right to health in international law presents a significant challenge".¹⁴⁵ There have been concerns as to the interpretation of the scope and content of the right to health. For a child's right to healthcare, the exceptionally detailed nature of Article 24 should be enough to establish at least a basic

¹⁴² Tobin J (n 56) 69.

¹⁴³ Ooms G, and Hammonds R (n 139) 38-9.

¹⁴⁴ Craven M (n 113) 75.

¹⁴⁵ Tobin J (n 56) 75.

understanding of what the right to health means. As mentioned, for the ICESCR, the Committee has seen fit to publish General Comment 14, and for the CRC it has published General Comment 15,¹⁴⁶ which both focus particularly on adding detailed substance to the right to health, what it means, the expectations of the State, and the official interpretation of the Articles.¹⁴⁷ Much of the language of General Comment 14 is similar to the ICESCR but it places a greater emphasis on the requirement of accessibility in paragraph 12 (b) which is broken down to include health services being “accessible to all . . . in law and in fact” as well as “affordable to all . . . based on the principle of equity”.¹⁴⁸ Indeed the right to health is broken down in to four principles which are essential elements of the right; availability, accessibility, acceptability, and quality.¹⁴⁹ This breakdown by the CESCR assists the understanding of practical measures required to be taken in order to change what is otherwise an idealistic goal into a tangible guarantee that can be claimed by an individual.¹⁵⁰ Availability requires, *inter alia*, access to trained medical professionals and essential drugs, as determined by the WHO.¹⁵¹ Tobin argues what the CESCR says about availability offers an expansive and demanding list of services, and therefore offers clarity to the goal of progressive realisation.¹⁵² Accessibility is broken down itself in to four sub-categories: non-discrimination, physical reach, economic and information. Barriers to healthcare services should not be based on any of these things. Acceptability means healthcare must be culturally appropriate

¹⁴⁶ Committee on the Rights of the Child, *General Comment No 15* on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) CRC/C/GC/15 (2013).

¹⁴⁷ General Comment 14; da Costa Leite Borges D (n 56) 337; see also Easley CE, Marks SP, and Morgan Jr RE (n 6) 1923.

¹⁴⁸ General Comment 14, 12.

¹⁴⁹ *ibid.*

¹⁵⁰ Tobin J (n 56) 158.

¹⁵¹ The WHO maintains a list of ‘essential medicines’ that should be available in all countries. Most are not expensive, many are off-patents, and so cost is not the main reason they are not provided. It has been argued that it is often infrastructure, which may be inept or corrupt governments, or even a lack of roads and inability to get the medicines to where they are needed. In this way the interconnected nature of all human rights is seen. See Wolff J (n 4) 127.

¹⁵² Tobin J (n 56) 159.

and quality demands medically appropriate care without basic failures such as out of date drugs or treatments.¹⁵³ It is argued that such content is not clear enough to properly monitor compliance because it remains far from precise what is expected of a State.¹⁵⁴ This is a difficulty, as each State will be different, and the way any State implements the right must be culturally sensitive, yet there is a requirement to monitor progress so that compliance can be seen. Wolff acknowledges that it is unclear what the correct answer is, with interpretation remaining relatively and necessarily fluid.¹⁵⁵

All of these measures are subject to a State's resources meaning that the UN Committees cannot mandate States to provide them; a weakness discussed more in the next section.¹⁵⁶ The only measures that are not subject to a State's limited resources are those which are considered part of the minimum core. These include essential primary care in conjunction with contemporary instruments such as the Alma-Ata Declaration,¹⁵⁷ access to health facilities,¹⁵⁸ essential drugs,¹⁵⁹ and a national health plan with monitoring of indicators to measure progress,¹⁶⁰ and immunisation against major infectious diseases.¹⁶¹ The idea of the minimum core was introduced in General Comment 3, but in General Comment 14 the CESCR provided much greater detail of what it considered were the core obligations of the right to health. Interestingly the minimum core is not expressly adopted in the CRC or by the CCRC in its General Comments.¹⁶² The CCRC, for example, has not held States accountable in their concluding observations for failure to immediately satisfy

¹⁵³ General Comment 14, 12.

¹⁵⁴ Wolff J (n 51) 32.

¹⁵⁵ Wolff J (n 51).

¹⁵⁶ Tobin J (n 56) 171.

¹⁵⁷ General Comment 14, 43.

¹⁵⁸ *ibid* 43 (a).

¹⁵⁹ *ibid* 43 (d).

¹⁶⁰ *ibid* 43 (f).

¹⁶¹ *ibid* 44 (b).

¹⁶² Reinbold GW (n 52) 17.

the minimum core obligations of a child's right to health.¹⁶³ The reason why this is the case is unclear and it is submitted here that this may be an oversight rather than a deliberate retreat from the idea of a minimum core, especially given the WHO indicators and Millennium Development Goals discussed in the first chapter. Even so, if this is an oversight by the CCRC, it is disappointing and reduces the sincerity and determination the UN has to ensuring the minimum core as a basic level that should be and can be achieved in all States.

Tobin argues the minimum core is an impractical idea as many States will not be able to achieve even this basic level of protection and provision, so in reality it too is subject to progressive realisation.¹⁶⁴ He goes as far as to call the minimum core of General Comment 14 'unprincipled', 'impractical', and 'onerous'.¹⁶⁵ It will be seen that whilst some countries will not be able to afford a basic minimum of health care services unaided, it is still possible, with the requirement of international cooperation to make this minimum core a reality that can then be built upon. Tobin is right that many States have not embraced the minimum core, indeed the U.S. have not accepted General Comment 14 at all arguing that it goes far beyond the initial purpose of ICESCR and international law generally because it focuses on individuals and not deliberations between States.¹⁶⁶ It will be argued however that not embracing a minimum core concept is a missed opportunity that can be reversed. Tobin argues that defining a right to health requires adjudication which has not happened, especially at the international level,¹⁶⁷ and yet he also argues this would render the minimum core an inappropriate addition as courts lack the

¹⁶³ *ibid* 28.

¹⁶⁴ Tobin J (n 56) 97-98.

¹⁶⁵ *ibid* 117.

¹⁶⁶ Wolff J (n 51) 31; once again the hypocrisy of the United States bears its head as they criticise the interpretation of a Convention they have not ratified themselves.

¹⁶⁷ Tobin J (n 56) 76.

ability to interpret it. The idea of courts interpretation of the right including a minimum core will be argued for in the next chapter.

Others have argued that the right to health is “plagued by paradox”¹⁶⁸ because of the minimum core, with certain immediately enforceable elements of the right that go beyond resource constraints which would therefore seem to be contrary to the acceptance of progressive realisation.¹⁶⁹ The paradox is in having immediately enforceable elements of a right that is subject to progressive realisation. The problem is not so severe if it is accepted that such minimum standards possess the unique feature coined here of having the paradox of being fundamentally paramount. It may be a paradox, but an understandable and acceptable one nonetheless. The minimums are the most basic level expected; fundamental. And yet they are also of such vital importance; paramount. This is a paradox; but not a plague. Nor is it a severe problem. As Eletheriadis has argued:

Core obligations include access to essential drugs, water and sanitation and the setting up a national public health strategy, which must exhibit care for all. These are the things whose lack causes not only suffering and pain but also humiliation and exploitation. This is why such matters are moral fundamentals. Other matters could perhaps be left to ‘progressive realisation’ according to available resources.¹⁷⁰

It is argued that adding clear content to a right is also the only appropriate way to adjudicate it so that courts know exactly what had been guaranteed, although this itself gives rise to concerns that courts should not be involved in interpreting rights and delegating resources. So it seems clear from General Comment 14, focusing on Article 12 of the ICESCR that whatever healthcare services are being provided, they should be provided for all, and the vision for each of the 161 countries that have

¹⁶⁸ Chowdhury J, 'Judicial Adherence to a Minimum Core Approach to Socio-Economic Rights - A Comparative Perspective' (2009) Paper 27 Cornell Law School Inter-University Graduate Student Conference Papers 1.

¹⁶⁹ Wolff J (n 51) 11.

¹⁷⁰ Eletheriadis P, 'A Right to Health Care' (2012) 40 *Journal of Law, Medicine and Ethics* 268, 282.

ratified the ICESCR should be to eventually achieve universal coverage and access to healthcare services.

2.3.1.3 Monitoring Mechanisms

The ICESCR entered into force with the required 35 ratifications¹⁷¹ and has been signed but not ratified by only 6 countries, including the United States.¹⁷² Ratification means that the CESCER will monitor the implementation of the convention in that country, with no mechanism for enforcing obligations under the treaties.¹⁷³ Monitoring occurs by requiring the State parties to submit periodic reports,¹⁷⁴ one in the first two years and then every five years after that, which the State itself writes on how the rights are being implemented. This is the same for the CRC. From this, the Committee submits concluding observations with concerns and recommendations to each State party.¹⁷⁵ The Committee also considers shadow reports by NGOs, such as the WHO, which, in theory are provided without bias and deliver the Committee useful guidance on their goals and indicators.¹⁷⁶

The Committee reporting process has been criticised as often focusing on a few successes and avoiding any failures. Some have also criticised the heavy burden

¹⁷¹ *International Covenant on Economic, Social and Cultural Rights* (1966), Article 27; see also Kinney ED (n 54) 339.

¹⁷² Office of the High Commissioner for Human Rights; Ratification Status for CESCER - International Covenant on Economic, Social and Cultural Rights
<http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?Treaty=CESCR&Lang=en>last viewed 23/09/2015.

¹⁷³ Reinbold GW (n 52) 20.

¹⁷⁴ Mann J, and others (n 52) 10.

¹⁷⁵ Committee on Economic, Social and Cultural Rights: Monitoring the economic, social and cultural rights, <<http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIntro.aspx>>last viewed 23/09/2015; typically a reporting cycle of the State party consists of the initial report by the State according to Committee guidelines, issues for additional information requested by the Committee, the State's reply to this request, meetings between the State and the Committee to discuss the report, and then finally the concluding observations of the Committee; Reinbold GW (n 52) 23.

¹⁷⁶ Leary VA (n 64) 43.

the reporting process places on developing States with many reports being late, sometimes twelve years after they were due.¹⁷⁷ Equally the recommendations by the Committee are not legally binding meaning implementation rests on the responsiveness and political will of the States and the idea that shame may provide needed pressure.¹⁷⁸ Freeman, in the context of the CRC, points out that there are “no real teeth”¹⁷⁹ in the provisions enforcing it, and suggests that if the Committee is to remain the fulcrum of enforcement, it should be permanent and given more powers.¹⁸⁰ Reinbold argues that the ineffectiveness of the reporting process is one of the key factors the CRC could not ensure achievement of the millennium development goals.¹⁸¹ This ineffectiveness is one of the main reasons the idea of court enforcement of human rights is explored in this thesis. Examples of concluding observations from the CCRC to South Africa and Brazil can provide support to the academic criticism that there are no real teeth in the current monitoring system.

As far back as 2000, the CCRC issued a concluding observation for South Africa which raised many concerns that were still present in the chapter one research carried out 15 years later.¹⁸² There were specific concerns over the lack of data collection in South Africa, which was seen in chapter one as still being a major problem in determining any progress in certain areas of healthcare. Concerns were also raised about the lack of primary and basic healthcare, with the CCRC requesting South Africa to focus on reducing the infant mortality rate. As seen in chapter one, the rate only dropped by 6 per 1,000 live births between 1990 and 2010. Concerns were also raised over HIV/AIDS treatment, for which no

¹⁷⁷ O'Brien D, and Smith R, 'Realising the Right to Health of Young People in South Africa – Some Reflections' (2016) 105 *The Round Table: The Commonwealth Journal of International Affairs* 4, 393; Reinbold GW (n 52) 25.

¹⁷⁸ Tomás C (n 96); Freeman M, 'The Future of Children's Rights' (2000) 14 *Children and Society* 277.

¹⁷⁹ Freeman M, 'The Future of Children's Rights' (n 178) 290.

¹⁸⁰ *ibid.*

¹⁸¹ Reinbold GW (n 52) 45.

¹⁸² Committee on the Rights of the Child, *UN Committee on the Rights of the Child: Concluding Observations: South Africa*, 28 January 2000, U.N. Doc. CRC/C/15/Add.122.

improvement was made until the TAC case two years later (see below). If South Africa had listened to the concluding observations then the case would not have needed to be brought. Finally, the CCRC raised concerns over South Africa's lack of ratification of ICESCR and strongly urged it to ratify the convention. In another piece of clear evidence that the concluding observations are not especially heeded, it took South Africa a further 15 years to do so. Equally, South Africa's next report to the CCRC was due in 2002, yet it was not submitted until 2014, demonstrating why more recent concluding observations cannot be considered; none exist. The 2014 report has not yet been considered.¹⁸³

As for Brazil, a concluding observation in 2004 again expresses many concerns which are raised in this thesis and throughout recent academic literature showing a clear lack of improvement or adherence to the observations.¹⁸⁴ Specifically, the CCRC expressed concerns over the large inequality in healthcare, expressing concerns over the rural poor and their inability to access appropriate healthcare in spite of a good universal system. It is important to note that these people will be those least likely to be able to access the courts, which is a large contributing factor to such inequality. Equally, the CCRC expressed concerns on the lack of information on budget allocations and lack of consideration of the most vulnerable. These two concerns, inequality and budget allocations, are still the main problematic areas for healthcare in Brazil.

These concluding observations serve as evidence of the lack of teeth that the current reporting procedure has which is why many authors and this thesis search for different ideas as to how to monitor and implement human rights. For instance Buerghenthal suggests that the 6 reporting Committees should be replaced by 2 that

¹⁸³ O'Brien D, and Smith R (n 177) 393

¹⁸⁴ Committee on the Rights of the Child, *UN Committee on the Rights of the Child: Concluding Observations: Brazil*, 3 November 2004, CRC/C/15/Add.241.

focus on all the human rights treaties; one which focuses on State reports, whilst the other focuses on individual and inter-State complaints.¹⁸⁵

That ESC rights lack “appropriate enforcement mechanisms at the international level”¹⁸⁶ has been admitted by Navi Pillay herself, the UN High Commissioner for Human Rights, yet she suggests the optional protocol to the ICESCR will address this. Individual communications were omitted to begin with because it was believed that ESC rights would be inappropriate for such a complaints procedure, in a similar belief against the justiciability of ESC rights,¹⁸⁷ countered in the next chapter. Individual communications from citizens of State parties to the ICESCR may also now be considered due to an Optional Protocol of 2013. However it took four years for this protocol to enter into force with the required 10 State parties and it still only has 21 parties, the last being San Marino in August 2015.¹⁸⁸ Unfortunately, despite now entering into force, individual communications can still only be heard from citizens of the States that have ratified the optional protocol.

Another mechanism used by the Committee to aid States in implementing rights and provide a gentle form of enforcement is the publication of General Comments which interpret the rights and provisions of the ICESCR so that States know what is expected of them. Making State obligations clear makes violations much easier to establish and can help people be more assured in what their rights actually mean such as the requirement of immunisation and a focus on primary health care.¹⁸⁹ The implementation of the CRC is similar to that of the ICESCR, being overseen by a Committee on the Rights of the Child (CCRC) which consists of a panel of 18

¹⁸⁵ Buergenthal T, 'A Court and Two Consolidated Treaty Bodies' in Bayefsky AF (ed), *The UN Human Rights Treaty System in the 21st Century* (Kluwer Law International 2000) 300.

¹⁸⁶ Pillay N, 'Human Rights in United Nations Action: norms, institutions and leadership' (2009) 9 *European Human Rights Law Review* 1, 2.

¹⁸⁷ Van Bueren G (n 2) 388.

¹⁸⁸ United Nations Treaty Collection

<https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3-a&chapter=4&lang=en>last viewed 03/04/2016.

¹⁸⁹ General Comment 14.

experts elected after nomination from State Parties for a term of 4 years. Again reports are required from State parties in the first two years after ratification and then every five years after that, before the CCRC prepares its concluding observation and recommendations for each State party.¹⁹⁰ The CRC also has an optional protocol, its third, which will allow children to make direct complaints to the Committee. This opened for signature in February 2012, and entered into force on 14th April 2014, 3 months after Costa Rica became the 10th country to ratify it.¹⁹¹ Only 14 countries as of November 2014 have ratified the third optional protocol, including Germany. The CCRC can also use data from NGOs and add that to its comments as well as petition the UN to undertake studies on certain issues if it feels it is appropriate.¹⁹² However, the main advantage and difference of the CRC over the ICESCR and its Committees, is the CRC's near universal ratification mentioned above. Despite this, the recommendations of the Committee are insufficient to improve a child's right to health.¹⁹³

All of the UN Committees are non-judicial bodies with clear limits to their jurisdiction. They work with other bodies of the UN, particularly the Economic and Social Council and the General Assembly, which may result in technical assistance being provided to certain countries based on their reports.¹⁹⁴ The popularity of the CRC has led to the CCRC requesting more meetings to discuss the reports, and also "[u]nlike other reporting systems . . . the [CCRC] requires that governments publish the reports within their jurisdiction and disseminate the observations of the Committee."¹⁹⁵ The reporting system however has been criticised as weak because there is little that

¹⁹⁰ Doek JE (n 53).

¹⁹¹ Committee on the Rights of the Child: Monitoring children's rights
<https://treaties.un.org/pages/viewdetails.aspx?src=treaty&mtmsg_no=iv-11-d&chapter=4&lang=en> last viewed 05/01/2015.

¹⁹² Kasper J, and Wise PH (n 57) 71.

¹⁹³ Doek JE (n 53) 161.

¹⁹⁴ Smith RKM (n 49) 47.

¹⁹⁵ *ibid* 80.

can be done should a State choose to ignore the concluding observations with few legal sanctions to compel States to realise their human rights obligations.¹⁹⁶ Indeed it is widely seen as one of the weakest forms of enforcement¹⁹⁷ and it can be argued that this has led to the lackadaisical attitude of many countries towards the reporting process.¹⁹⁸ The Convention does not state any consequences for failure to report or non-compliance with the Convention, and as such it has been suggested that the rights are more idealistic goals and aspirations than tangible guarantees with legal effect.¹⁹⁹ This is why discussion will move to a focus on domestic enforcement in the next chapters, so as to transform these lofty ideas into a practical reality.²⁰⁰ Additionally, the rights cannot actually be demanded in a powerful way and the influence of human rights on State action is not very extensive because there is no institution set-up to claim the rights on behalf of a particular child.²⁰¹ This will be further discussed in the forthcoming chapters where the prospect of claiming such rights through the courts is discussed in chapter three and globalising this idea is analysed in Part B. Contrastingly, the report mechanism has equally been suggested to be a positive exercise that leads to open dialogue and inclusiveness that can be a honest appraisal of rights fulfilment and “identify technical or vocational assistance the State may require in fulfilling its obligations.”²⁰² However reports are often late and without any sanctions, preventing them from functioning as enforcement measures.²⁰³

¹⁹⁶ Freeman M, 'The Limits of Children's Rights' (n 48); see also Burman E (n 48) 50; see also Mann J, and others (n 52) 10.

¹⁹⁷ Van Bueren G (n 2) 379.

¹⁹⁸ O'Brien D, and Smith R (n 177) 393; Bates E (n 48) 267-268.

¹⁹⁹ Burman E (n 48) 50; see also Freeman M, 'The Limits of Children's Rights' (n 48); see also Freeman M, 'Laws, Conventions and Rights' (n 48); see also Bates E (n 48).

²⁰⁰ Easley CE, Marks SP, and Morgan Jr RE (n 6) 1922.

²⁰¹ O'Neill O, 'Children's Rights and Children's Lives' (n 19) 460; see also Brown C (n 126) 53.

²⁰² Smith RKM (n 49) 154.

²⁰³ *ibid* 155.

Thus one of the main problems of international human rights law has been highlighted; enforcement, or lack thereof. The formal acknowledgement of a child's right to healthcare is promising but is far from a guarantee of promotion and implementation. As it is, the reporting system cannot offer this guarantee and the promise of the near universal ratification of the CRC may be meaningless. Tomás argues that without better enforcement for guaranteeing the CRC, it is quite possible that in a decade it will still only be the most ratified international document without the universally recognised rights being put into practice.²⁰⁴ Freeman suggests that the "model of the European Convention on Human Rights is instructive. The sight of children hauling their own States before an international court would be particularly gratifying."²⁰⁵ Thus it seems that lessons can be learned from regional systems which are now clearly part of human rights protection and may provide better implementation strategies for a child's right to healthcare.

2.4 Regional Variations

In addition to these international documents recognising the universal right to health there are regional agreements, charters and conventions that have similar objectives.²⁰⁶ In Europe Article 11 of the European Social Charter²⁰⁷ recognises the right to health, although this is more shaped towards creating a healthy environment and eliminating the causes of ill health. The Charter of Fundamental Rights of the

²⁰⁴ Tomás C (n 96).

²⁰⁵ Freeman M, 'The Future of Children's Rights' (n 178) 290.

²⁰⁶ Tobin J (n 56) 19.

²⁰⁷ Council Of Europe, *European Social Charter* (1961) (revised 1996).

European Union (2000) also includes the right to health care in Article 35.²⁰⁸ Article 16 of the African Charter on Human and Peoples' Rights also recognises the right to health. In similar language to the UN documents and it declares a right of every individual to the "best attainable state of physical and mental health."²⁰⁹ Also the African Charter on the Rights and Welfare of the Child (1990) includes a long and very detailed article on the right to health and health services in Article 14, firstly using 'best attainable' language, and then, in section 2 listing specific measures for which the full implementation should be pursued.²¹⁰ In the Organization of American States (OAS), the American Declaration of the Rights and Duties of Man mentions a right to medical care in Article 11.²¹¹ The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador),²¹² places the right to health in Article 10 using similar words to those found in Article 12 of the ICESCR and Article 24 of the CRC. The

²⁰⁸ European Convention, *Charter of Fundamental Rights of the European Union* (2000).

²⁰⁹ Organisation Of African Unity, *African Charter on Human and Peoples' Rights* (1981) Article 16.

²¹⁰ Organisation Of African Unity, *African Charter on the Rights and Welfare of the Child* (1990), article 14: (1) Every child shall have the right to enjoy the best attainable state of physical, mental, and spiritual health: (2) States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures: (a) to reduce infant and child mortality rate; (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) to ensure the provision of adequate nutrition and safe drinking water; (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers; (f) to develop preventive health care and family life education and provision of service; (g) to integrate basic health service programmes in national development plans; (h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents; (i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children; (j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

²¹¹ Organization Of American States, *American Declaration of the Rights and Duties of Man* (1988). "Every person has the right to the preservation of his health through sanitary and social measures relating to . . . medical care, to the extent permitted by public and community resources."

²¹² Organization Of American States, *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador"* (1988).

Protocol seeks to ensure everyone the right to health and includes specific health benefits such as “[u]niversal immunization against the principle infectious diseases.”²¹³

It seems clear that regional human rights organisations have also tried to confer a right to healthcare through various charters and protocols. Some instruments differ in clarity and specificity, and some differ in legitimacy and in their legally binding nature. Thus the next stage is to set out what this established right actually means to the children who are intended to benefit from it. As chapter one established that the right is not being fulfilled in many places, searching for a remedy for such violations in international law is the aim of the remainder of this thesis. Firstly discussion must focus on the current strategies in place to give effect to the rights indicated above. Some work; some do not; and lessons can be taken from some of the successful systems.

2.4.1 Regional human rights law

²¹³ *ibid* Article 10 (2)(c). For the Arab League the appropriate instrument is the Arab Charter on Human Rights 2004, which entered into force in 2008 after it received the required seven ratifications and ensures a right to healthcare. Article 38 is very similar to Article 25 on the UDHR but does not mention medical care. Instead the Charter sets aside a specific Article for the right to healthcare in Article 39. In Asia, the Association of South East Asian Nations (ASEAN) has been established since 1967 but has not yet created a document mentioning the right to health. The Asian Human Rights Charter, set up by the Asian Human Rights Committee and NGOs, does mention the right to health but this is not international law as the committee is not a charter for nations by nations. Rather it is an attempt “to create in Asia a popular human rights culture” and present the people’s view as against some leaders who see human rights as alien to Asia. However, in 2007 a charter was adopted by ASEAN with the aim of providing the association with similar legal personality to the EU. See League Of Arab Nations, *Arab Charter on Human Rights* (2004); Smith RKM (n 49) 92; Asian Human Rights Commission, *Our Common Humanity: Asian Human Rights Charter: A People's Charter* (1998); Association of Southeast Asian Nations, *ASEAN Charter* (2007) Chapter II, Article 3; Lin CH, ‘ASEAN Charter: Deeper, Regional Integration under International Law?’ (2010) 9 Chinese Journal of International Law 821, 824; Lawrence N, ‘The ASEAN Charter: A Human Rights Whitewash?’ *The Irrawaddy* vol 17 (Burma, Feb 2009).

2.4.1.1 Organization of American States

The Organization of American States (OAS) is the oldest regional inter-governmental body in the world,²¹⁴ existing in different formats since the 19th century, but this does not mean it is the most advanced or successful in implementing human rights. As mentioned above, the right to health is found in the American Declaration and the Protocol of San Salvador. The declaration applies to all member States of the OAS, however it is not legally binding. Initially there was also no monitoring or implementation procedure, until the Inter-American Commission on Human Rights was established in 1959. The Protocol of San Salvador is an optional protocol to the American Convention on Human Rights, which established the Inter-American Court of Human Rights.²¹⁵ It has been suggested that the Court's possibility of having a more advisory role in interpreting the Convention could improve upon the European Court procedures.²¹⁶ However one major criticism and difference from Europe in the OAS system is that upon ratification of the Convention countries choose whether to accept the jurisdiction of the Court. Similarly in the Convention the right to health is also not mentioned although children are given specific mention with their own article guaranteeing their protection.²¹⁷ Under the Protocol of San Salvador it seems that the right to health is brought within the ambit of the Court for those countries that have accepted the Court's jurisdiction *and* ratified the Protocol, but cases are only brought before the court by the Commission or by contracting States, and, as it is, very few contentious cases have been heard.²¹⁸ This has the potential to develop, and it will be interesting to see a case adjudicating the right to health. At present it is the Commission that is the main

²¹⁴ Van Bueren G (n 2) 23 and 404.

²¹⁵ *American Convention on Human Rights* (1969); Smith RKM (n 49) 119.

²¹⁶ Van Bueren G (n 2) 23; see also *American Convention on Human Rights* (1969) Article 64.

²¹⁷ *American Convention on Human Rights* (1969) Article 19.

²¹⁸ Smith RKM (n 49) 134.

monitoring body of the OAS. The Commission acts slightly differently to its UN counterparts, with on-site visits, active investigations and reports, and the mandate to investigate all members of the OAS, regardless of ratification of the convention thus making its reporting process much more substantial. Also the Court can consider cases from States which accept its jurisdiction.²¹⁹ Thus different States within the OAS are subject to different monitoring and enforcement mechanisms with the reports and investigations of the Commission being the most common. Whilst these reports are more substantial than those of the UN Committees, and all members are potentially investigated, the OAS faces the same problem of hoping that the publicity and embarrassing nature of a negative report will be enough to persuade a State to change.

2.4.1.2 African Union

The African Union, formerly the Organisation of African Unity (OAU),²²⁰ is much more similar to the UN Committees in its monitoring of human rights. The OAU had a doctrine of non-interference²²¹ which became embarrassing for African nations given the atrocities that were occurring and frequently being ignored, and therefore the African Union has at least tried to be more aggressive with potential for real enforcement and even potential to intervene unilaterally to prevent war crimes.²²² The African Commission on Human and Peoples' Rights was established in 1987 and receives reports from contracting parties to the African Charter every two

²¹⁹ *ibid* 128.

²²⁰ Murray R, 'International Human Rights: Neglect of Perspectives From African Institutions' (2006) 55 *International and Comparative Law Quarterly* 193, 194.

²²¹ Akonor K, 'Assessing the African Union's Right of Humanitarian Intervention' (2010) 29 *Criminal Justice Ethics* 157, 157.

²²² African Unions, *The Constitutive Act of the African Union* (2000) Article 4 (h).

years.²²³ The OAU then adopted the Charter on the Rights and Welfare of the Child in 1999 becoming the first regional binding document specifically on the rights of the child.²²⁴ All but 13 member States have ratified this Charter with only 4 neglecting to sign or ratifying it.²²⁵ A Committee of Experts monitors the rights in the Charter which can receive individual complaints or communications from any person, group or NGO recognised by the Union, meaning, promisingly, there is no victim requirement.²²⁶ This has led to cases being brought by individuals and NGOs for violations of various rights and law in general.²²⁷ Aside from this, the reporting mechanism is very similar to that seen in the UN, however a Protocol to the African Charter on the Establishment of the African Court on Human and Peoples' Rights (1998) created a court whose jurisdiction "shall extend to all cases and disputes submitted to it concerning the interpretation and application of the Charter, this Protocol, and any other relevant Human Rights instrument ratified by the States concerned."²²⁸ Twenty-six States now recognise the jurisdiction of the court with cases being brought by the Commission or States. The States themselves can decide if NGOs and individuals are allowed to bring cases to the court, with only five doing so so far.²²⁹ The court's decision is final and binding, and appropriate measures of redress such as compensation or orders to adopt certain provisional measures can be ordered.²³⁰ This again has the potential to be a powerful enforcement mechanism of human rights that is not yet being fully realised. The African Union is too similar to the OAU it replaced in maintaining the doctrine of

²²³ Smith RKM (n 49) 143; Murray R (n 220).

²²⁴ Van Bueren G (n 2) 22.

²²⁵ <<http://www.achpr.org/instruments/child/ratification/>> last viewed 02/09/2015.

²²⁶ *African Charter on the Rights and Welfare of the Child* (1990) Article 44 (1); Murray R (n 220) 194.

²²⁷ Murray R (n 220) 199; see also for example Amnesty International case, *Annette Pagnoulle [of Amnesty International] (on behalf of Abdoulaye Mazou) vs. Cameroon*. (African Commission on Human and Peoples' Rights, Comm. No. 39/90, 1997).

²²⁸ Organisation Of African Unity, *Protocol to the African Charter on Human and Peoples' Rights on the Establishment of the African Court on Human and Peoples' Rights* (1998) Article 3.

²²⁹ Smith RKM (n 49) 144.

²³⁰ *ibid.*

non-interference.²³¹ The reporting system is weak, with the work of the Commission being called pathetic by some.²³² Murray however criticises this and the space given in international law textbooks to the work of the Commission because it serves to feed a stereotype of poor human rights implementation.²³³ The Commission is very open in its participation and whilst Murray is right that it has found violations in many areas and commented on them, this has not led to drastic human rights implementation. Indeed the Commission has not found violations in many cases where it would seem obvious, and the naivety in accepting government's responses is worrying.²³⁴ In some cases it has taken eight years for the Commission to reach decisions because of its determination to hear from governments.²³⁵ However, the court system has potential not yet realised. There is no criminal jurisdiction which has caused many problems for leaders accused of war crimes where the courts have refused to hear a case because of a lack of jurisdiction.²³⁶ However more countries could grant individual access to the court as well as for NGOs which could make a real difference if better enforcement mechanisms are put in place as well.²³⁷

2.4.1.3 Europe

²³¹ Akonor K (n 221) 167.

²³² Lloyd A, 'Evolution of the African Charter on the Rights and Welfare of the Child and the African Committee of Experts: Raising the gauntlet' (2002) 10 *The International Journal of Children's Rights* 179, 179; Murray R (n 220) 195.

²³³ *ibid.*

²³⁴ Murray R (n 220) 164.

²³⁵ *ibid.* 165.

²³⁶ African Union, *Report of the Committee of Eminent African Jurists on the Case Hissène Habré* (2006) Section IV, B, III (c) where it was determined that the former president of Chad Hissène Habré's case could not be heard by the African Court because of a lack of jurisdiction.

²³⁷ Akonor K (n 221).

Europe is widely considered as the most successful implementer of human rights.²³⁸ It is different in its legal system to both domestic and *traditional* international law and has been compared to a constitutionalised system of government.²³⁹ This comparison becomes important when discussing ways to think about international human rights in chapter six. As mentioned above, the right to health in Europe is only present in the European Social Charter and the Charter of Fundamental Rights of the European Union,²⁴⁰ which stem from the two separate bodies in Europe. The European Social Charter comes from the Council of Europe, the same body that established the European Convention on Human Rights, and the Social Charter is considered a complement to the Convention.²⁴¹ The Charter of Fundamental Rights is part of the European Union. In discussing the complexity of Europe, firstly the Council of Europe will be addressed with the way it implements human rights. Secondly the European Union will be considered with its complex legal structure before finally analysing the interaction between the two separate institutions within Europe that help protect human rights. Each body is considered in turn.

2.4.1.3.1 Council of Europe

The Council of Europe, founded in 1949, wrote the European Convention of Human Rights (ECHR), which entered into force in 1953, and was the first international

²³⁸ See footnote 49.

²³⁹ Hervey TK, and McHale JV (n 56) 236; Eckes C, 'EU Accession to the ECHR: Between Autonomy and Adaptation' (2013) 76 *The Modern Law Review* 254, 260.

²⁴⁰ Some argue that the right to health is considered as part of the right to life in the European Convention on Human Rights, see *da Costa Leite Borges D* (n 56) 339; also in May 2013 there was a high level meeting with 150 representatives of EU member states and neighbours entitled 'Right to health right to life'; see also Council of Europe, *Digest of the Case Law of the European Committee of Social Rights* (2008) 81 where the Committee of Social Rights states that Article 11 of the Charter complements Articles 2 and 3 of the Convention; see also *Osman v United Kingdom* (1998) ECHR 23452/94 and *Scialacqua v. Italy* (1998) 34151/96 DR; *Powell v. United Kingdom* (2000) ECHR 45305/99; see also McHale JV, 'Commentary: Rights to Medical Treatment in EU Law' (2007) 15 *Medical Law Review* 99, 286.

²⁴¹ *da Costa Leite Borges D* (n 56) 339.

agreement to give human rights enforcement machinery.²⁴² It established the European Court of Human Rights (ECtHR), which, along with the now defunct European Commission of Human Rights, has created detailed jurisprudence on rights and led to enforcement of human rights within the member States to the Council of Europe. The Court has sought to ensure that the Convention has real force and real impact: “The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective”.²⁴³ As regards children, the Convention refers to “everyone” and children have successfully brought cases to the court.²⁴⁴ However, the ECHR only enshrines civil and political rights offering no protection for ESC rights.²⁴⁵ The right to health is in the European Social Charter and is therefore non-justiciable. It is monitored and enforced by a reporting mechanism and conclusions delivered by the European Committee of Social Rights.²⁴⁶ The Charter is not binding and therefore is not subject to the jurisdiction of the ECtHR.²⁴⁷ Every year State parties submit a report to the European Committee of Social Rights which then publishes its conclusions. Under an optional protocol²⁴⁸ to the European Social Charter, various NGOs are now able to submit complaints to the Committee, if the State has agreed and ratified the protocol, however only 15 of the possible 47 States have agreed to this with the

²⁴² Van Bueren G (n 2) 22.

²⁴³ *Artico v Italy* (1980) ECHR 6694/74, para 33.

²⁴⁴ See *Tyrer v United Kingdom* (1978) ECHR 5856/72 where a 15 year old successfully challenged birching as a punishment as it breached his Article 3 rights; see also *Nielson v Denmark* (1988) ECHR 10929/84 where a 12 year old sought to find a breach of his Article 5 rights when his mother requested his hospitalisation. The Court agreed that Article 5 applied to minors but found no violation in this instance as hospitalisation was a responsible exercise of parental rights.

²⁴⁵ Warbrick C, 'Economic and Social Interests and the European Convention on Human Rights' in Baderin M, and McCorquodale, R. (ed), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007) 241.

²⁴⁶ da Costa Leite Borges D (n 56) 340.

²⁴⁷ *ibid* 339.

²⁴⁸ Council of Europe, *Additional Protocol to the European Social Charter Providing for a System of Collective Complaints* ETS No. 158 (1998).

UK and Germany being notable absentees.²⁴⁹ There remains no mechanism for individual complaints.²⁵⁰ The European Committee of Social Rights has interpreted the Social Charter and Article 11, the right to the protection of health, to clearly envision a healthcare system that is accessible to all without any discrimination.²⁵¹ The Social Charter does make more specific reference to children, but focuses on hazards they are exposed to and work rights, rather than any detailed minimum of child health provision.²⁵²

However, it is frequently suggested that the human rights enforcement of the Council of Europe and the Court has been, or at least is now, a resounding success.²⁵³ This is because the members of the Council of Europe are leaders of governments that have agreed to be bound by the jurisdiction of the Court, thus giving effect to judgments and negating the problem experienced in other systems where there is a lack of political will. In order to be a member of the Council of Europe a State must ratify the ECHR and *ergo* accept the jurisdiction of the ECtHR, which is one of the main reasons for such effective implementation and enforcement:²⁵⁴ “Compulsory jurisdiction of human rights courts, in the strong sense as a condition of membership, remains limited to the [European Court of Human Rights] ECtHR.”²⁵⁵ This compulsory jurisdiction was established with Protocol 11 to the Convention which all 47 members have ratified, which also allowed individual

²⁴⁹ Council of Europe, *Human Rights and Rule of Law: Organisations entitled to lodge complaints with the Committee* <http://www.coe.int/t/dghl/monitoring/socialcharter/OrganisationsEntitled/OrgEntitled_en.asp> last viewed 14/03/2015.

²⁵⁰ Warbrick C (n 245).

²⁵¹ Council of Europe (n 240) 82; see also da Costa Leite Borges D (n 56) 340.

²⁵² Council of Europe, *European Social Charter* (1961 (revised 1996)) part 1 article 7.

²⁵³ O’Boyle M (n 49); see also Green A (n 49) 71.

²⁵⁴ O’Boyle M (n 49) 170; see also *Parliamentary Assembly of the Council of Europe Resolution 1031* (1994) on the honouring of commitments entered into by member states when joining the Council of Europe, no. 9 “The Assembly recalls in this connection that accession to the Council of Europe must go together with becoming a party to the European Convention on Human Rights. It therefore considers that the ratification procedure should normally be completed within one year after accession to the Statute and signature of the Convention.”; see also Green A (n 49) 71.

²⁵⁵ Gardbaum S (n 49) 761.

complaints straight to the Court.²⁵⁶ This has been argued to be very effective, even in relation to children's rights, where children have fully utilised the right of individual petition.²⁵⁷ The consistent case law and active powers of the Court serve as an excellent example for human rights enforcement for the rest of the world, even though different countries receive the decisions in different ways as the Convention does not require national courts be bound by its rulings.²⁵⁸ In Germany for example, any decision is given the status of ordinary law, and sits below the Constitution as an interpreting tool.²⁵⁹ Ordinary courts are obligated to apply the decisions however. In the UK, the decisions are not directly legally binding but are given effect by the Human Rights Act 1998. The UK Supreme Court should take in to account the decisions of the ECtHR, but on rare occasions it is open for it to not follow Strasbourg.²⁶⁰ This is the same situation as for international law with the level of incorporation dependent upon the State.²⁶¹ This has led some to suggest that in actual fact the enforcement mechanisms of the EU legal order are stronger than under the Convention, because of the primacy of EU law accepted by all member States as opposed to not all accepting the supremacy of the Convention. The Convention, unlike a State or the EU, is not its own self-contained legal order which can enforce its own laws.²⁶² Additionally, despite the success of human rights enforcement of the Council of Europe there is still no hard enforcement of ESC

²⁵⁶ Council of Europe, Treaty Office: *Protocol No. 11 to the Convention for the Protection of Human Rights and Fundamental Freedoms, restructuring the control machinery established thereby* (1998); the Convention is not one single catalogue of rights but also contains protocols which are established later and have to be ratified separately; see Eckes C (n 239) 271.

²⁵⁷ Van Bueren G (n 2) 379 and 411; see also Council of Europe, Treaty Office: *Protocol No. 11 to the Convention for the Protection of Human Rights and Fundamental Freedoms, restructuring the control machinery established thereby* (1998) Article 34.

²⁵⁸ Eckes C (n 239) 274-275; Lock T, 'The ECJ and the ECtHR: The Future Relationship between the Two European Courts' (2009) 8 *The Law and Practice of International Courts and Tribunals* 375, 386.

²⁵⁹ Eckes C (n 239) 275.

²⁶⁰ *ibid* 276; see also White Paper 'Rights Brought Home: The Human Rights Bill' Presented to Parliament by the Secretary of State for the Home Department by Command of Her Majesty, October 1997, Cm 3782

²⁶¹ Reinbold GW (n 52) 22.

²⁶² Eckes C (n 239) 278; Lock T (n 258) 394.

rights. The ECtHR has not, for example, favoured a general right to medical treatment, merely sticking to suggestions that it becomes a consideration as part of other rights such as to prevent discrimination or inhuman, degrading treatment.²⁶³ Indeed in *Powell*²⁶⁴ it was specifically stated that health care policy may engage the positive elements of the right to life, but then the Court deliberately restricted itself from going further leaving the right to health elements of the convention very limited. The Charters go some way to addressing the issue but they do not possess the “strong implementation mechanisms which characterize the European Convention.”²⁶⁵ The reporting system is generally considered weak in universal and regional systems, because it is dependent on State compliance,²⁶⁶ and there is little that can be done to States that choose not to comply except a few minor deterrents.²⁶⁷

2.4.1.3.2 European Union

The Charter of Fundamental Rights, which is to be applied by member States and institutions of the European Union when they are applying EU law, is also not without problems and complications. The EU has established the European Court of Justice or the Court of Justice of the European Union (CJEU), which is separate from the ECtHR, and is likely to use the Charter “when determining if their practice is in conformity with the general principles of law recognized and applied throughout the Union.”²⁶⁸ The Charter is legally binding since the Lisbon Treaty (2009) giving the Charter the same legal value as the Treaties. It is argued that the binding effect of the Charter means it is likely that the CJEU will use it much more often in

²⁶³ Warbrick C (n 245) 251-252.

²⁶⁴ *Powell v United Kingdom* (2000) ECHR 45305/99.

²⁶⁵ Smith RKM (n 49) 116.

²⁶⁶ Freeman M, ‘The Limits of Children’s Rights’ (n 48); see also Mann J, and others (n 52) 10; Burman E (n 48) 50; Smith RKM (n 49) 165.

²⁶⁷ Smith RKM (n 49) 172.

²⁶⁸ *ibid* 114.

decisions.²⁶⁹ However, it only applies to EU member States when they are implementing EU law. The interpretation of this, and how effective the CJEU is in implementing the rights, especially to healthcare and whether this is considered implementing EU law, is complicated. It is suggested that the rights in the Charter cannot be applied universally but only in relation to the EU and action taken within its institutions or under the treaty.²⁷⁰ The EU has shown increasing involvement in health care law and policy,²⁷¹ yet if an issue arises outside the scope of EU law then a human rights challenge would have to be brought before the ECtHR, if domestic remedies are exhausted.²⁷² The enforceability of rights in the EU will likely operate against EU institutions rather than national authorities, so it has been suggested the EU Charter may not provide the health care rights enforcement it promises.²⁷³ Standing before the CJEU is different and more difficult as there is no direct procedure for individuals to complain about a breach under the Charter, even though it is enforceable before the court.²⁷⁴

The right to health care in the EU Charter is contained in the Chapter entitled *Solidarity* where Article 35, which is based on Article 11 of the Social Charter,²⁷⁵ ensures everyone access to preventive health care and benefits from national laws and policies.²⁷⁶ Children are also given their own separate Article, Article 24, which guarantees their protection and consideration of their views on matters which affect them in accordance with their age and maturity. There is also the primacy of the best interests doctrine when any institution makes a decision on an action relating to

²⁶⁹ da Costa Leite Borges D (n 56) 341.

²⁷⁰ Miller V, *EU Accession to the European Convention on Human Rights* (Library of the House of Commons, SN/IA/5914, 2011) 7.

²⁷¹ McHale JV, 'Fundamental rights and health care' (n 240) 282.

²⁷² *ibid* 296.

²⁷³ *ibid* 313.

²⁷⁴ Eckes C (n 239) 280.

²⁷⁵ McHale JV, 'Fundamental rights and health care' (n 240) 303.

²⁷⁶ European Union, *Charter of Fundamental Freedoms of the European Union (adapted)* (2010/C 83/02, 2000).

children.²⁷⁷ Whilst the Charter has not long been in force (2009) Article 35 has most often been used in protection of health claims in connection with the environment or quality of goods.²⁷⁸ Health care also has an established jurisprudence in the EU in free movement claims where an individual is facing an undue delay to treatment in their own country and seeks treatment elsewhere within the EU and subsequently look for reimbursement for the additional expense.²⁷⁹ Recently such reimbursement from the national social insurance schemes has been very successful at the CJEU.²⁸⁰ Such jurisprudence has focused on the combination of the European Community Treaty²⁸¹ and Regulation No. 1408/71²⁸², where the Treaty enables free movement and the regulation allows patients to gain authorisation for their treatment overseas. It has been suggested that such litigation could be undermining member States autonomy to make resource decisions and care priorities, however the position of EU law remains quite limited and its application is through the national courts.²⁸³ The greatest impact of the EU will be seen in the broader scope of health and regulation on a variety of things that impact on health.²⁸⁴ It seems that the EU is

²⁷⁷ *ibid* Article 24.

²⁷⁸ Case C-376/98 *Germany v Parliament and Council (Tobacco Advertising)* [2000] ECR I-8419; Case C-343/09 *The Queen, on the application of Afton Chemical Limited v. Secretary of State for Transport* [2010] ECR I-7027; Case C-544/10 *Deutsches Weintor eG v. Land Rheinland-Pfalz* [2012] (Third Chamber, 6 September 2012); see Weatherill S, 'Why There Is No 'Principle of Mutual Recognition' In EU Law (and Why that Matters to Consumer Lawyers)' in Purnhagen K, and Rott P, (ed), *Varieties of European Economic Law and Regulation* (Springer International Publishing 2014) 401, 415; Everson M, and Gonçalves RC, 'Article 16 - Freedom to Conduct a Business' in Peers S, Hervey T, Kenner J, and Ward A (ed), *The EU Charter of Fundamental Rights: A Commentary* (Hart Publishing 2014) 452.

²⁷⁹ Case C-158/96 *Kohll v. Union des Caisses de Maladie* [1998] ECR I-1935 ; Case C-157/99 *Gerat Smits and Peerboom* [2001] ECR I-05473; Case C-368/98 *Vanbraekel* [2001] ECR I-5363; Case C-385/99 *Muller Faure* [2003] ECR I-4509; Case C-372/04 *Watts* [2006] ECR I-4325; Case C-466/04 *Herrera* [2006] ECR I-05341.

²⁸⁰ Hervey TK, and McHale JV (n 56) 249; McHale JV, 'Commentary: Rights to Medical Treatment in EU Law' (n 240) 101.

²⁸¹ Particularly Articles 59 and 60 of the *Treaty establishing the European Economic Community* (1957); later Articles 49 and 50 the *European Community Treaty* before it was abolished by the *Lisbon Treaty*. Now Articles 56 and 57 of the *Treaty on the Functioning of the European Union* (TFEU).

²⁸² Council of European Communities, *Regulation 1408/71 on the application of social security schemes to employed persons and their families moving within the Community* (1971).

²⁸³ Eckes C (n 239) 266 and 269; Hervey TK, and McHale JV (n 56) 250.

²⁸⁴ Hervey TK, and McHale JV (n 56) 259.

uneasy determining more specificity about healthcare systems however because it would be seen as overstepping the fundamental rights at the national level and undermining national policy.²⁸⁵ Some may suggest this is a weakness and a missed opportunity, but equally making decisions on such rights could divert resources from another person, or another right, and may not be a decision the EU should make. This problem of which institution should make such specific decisions will be seen in the next chapter as well, where the role of the courts is discussed. It is not contentious to accept that it is the role of a democratically elected government to decide their healthcare priorities and resource allocation across all services, including education and rehabilitation for example. This demonstrates the problem of where the courts and supranational organisations should be involved, if at all. It will be argued that the moral obligation to provide a basic minimum of healthcare services demands fulfilment of the minimum core. Health policies beyond this are the prerogative of the government yet the courts have their role in ensuring the legality, proportionality and reasonableness of such decisions. For now, discussion returns to the model of Europe and the interaction between the two institutions.

2.4.1.3.3 Interaction

2.4.1.3.3.1 Possible EU Accession to the European Convention

The two institutions of Europe do not act separately and their interactions have progressively become institutionalised norms.²⁸⁶ This is the same for the Courts, two of the busiest international Courts in the world.²⁸⁷ The relationship between the two bodies is complicated and could change drastically as it is under consideration for

²⁸⁵ McHale JV, 'Commentary: Rights to Medical Treatment in EU Law' (n 240) 106.

²⁸⁶ Eckes C (n 239) 256.

²⁸⁷ Lock T (n 258) 376.

the EU to accede to the European Convention.²⁸⁸ However the CJEU has opined against this accession, most recently because it believes it is not compatible with the Treaty on the European Union (TEU) for the EU to sign up to the ECHR.²⁸⁹ “[T]he fact remains that the agreement envisaged fails to have regard to the specific characteristics of EU law with regard to the judicial review of acts, actions or omissions on the part of the EU law in CFSP [Common Foreign and Security Policy] matters.”²⁹⁰ The CJEU is also very uncomfortable with the idea that the ECtHR would be able to make decisions based on EU law and surpass the CJEU.²⁹¹ The Court of Justice wants to preserve the autonomous EU legal order and its own jurisdiction over EU law.²⁹² The CJEU is very uncomfortable with the idea of accession by previously holding that the EU lacked the competence to enter into international agreements that would permit a different court to make binding decisions about EU law.²⁹³

However others believe that since Protocol 14 to the ECHR, which allowed the EU to accede to the Convention, and Article 6(2) of the Lisbon Treaty of the EU, which made it an obligation to accede to the Convention, the legal path has been paved.²⁹⁴ The relationship between the two European institutions is important and since Article 6 of the Lisbon treaty, exactly how interaction will operate remains to be seen.²⁹⁵ As Lock has argued, jurisdictional conflict is possible between the two courts and a resolution must be found.²⁹⁶ This has been attempted with draft

²⁸⁸ Indeed it has been for a long time and now Article 6 (2) of the *Lisbon Treaty* seemingly makes it an obligation for the EU to accede to the European Convention, European Union, *The Treaty of Lisbon* 2007/C 306/01 (2007); see also Smith RKM (n 49) 113; Eckes C (n 239) 254.

²⁸⁹ Court of Justice of the European Union *Opinion 2/13* (18 December 2014) Full Court, AG J. Kokott.

²⁹⁰ *ibid* para 257.

²⁹¹ *ibid*.

²⁹² Eckes C (n 239) 254.

²⁹³ Miller V (n 270) 10.

²⁹⁴ Eckes C (n 239) 263; Miller V (n 270) 5; Lock T (n 258) 387.

²⁹⁵ McHale JV, 'Fundamental rights and health care' (n 240) 297.

²⁹⁶ Lock T (n 258).

agreements that have been reached, but as noted above, the Court of Justice in December 2014 opined that this was still not legally acceptable.²⁹⁷ It is argued that the EU acceding to the Convention would likely mean supremacy of the European Court of Human Rights as the CJEU will be bound by certain decisions.²⁹⁸ It will mean many other drastic changes as well such as an EU judge sitting on the ECtHR, as every party to the Convention has a judge on the court, and individuals being able to bring EU institutions before that Court.²⁹⁹

2.4.1.3.3.2 *General Deference*

This accession has yet to happen and so it is worth discussing the current legal situation in Europe and the unique nature of having two separate Courts that adjudicate on human rights, and the interaction between the two courts. The most important case to illustrate the respect the institutions give each other is widely accepted as the *Bosphorus* case.³⁰⁰ Here the ECtHR established the *Bosphorus* presumption,³⁰¹ where the ECtHR will assume there is no violation if an action is taken in compliance with the obligations of membership of an international organisation if that organisation protects human rights in a manner equivalent to the Convention, and there was no discretion left to the State. The EU is considered such an organisation. Thus, this case established a presumption by the ECtHR that actions by the EU do not violate the convention. Lock says this is proof of the silent cooperation between the two Courts.³⁰² This is illustrating a general trend that in the past the Courts have demonstrated great deference to each other.³⁰³ The EU's

²⁹⁷ Court of Justice of the European Union *Opinion 2/13* (18 December 2014) Full Court, AG J. Kokott.

²⁹⁸ Lock T (n 258) 397.

²⁹⁹ Eckes C (n 239) 263 and 269.

³⁰⁰ *Bosphorus v Ireland* (2005) ECHR 45036/98; Lock T (n 258) 377; Callewaert J, 'The European Convention on Human Rights and European Union Law: a Long Way to Harmony' (2009) *European Human Rights Law Review* 768, 772.

³⁰¹ Eckes C (n 239) 261; Lock T (n 258) 378; Callewaert J (n 300) 772.

³⁰² Lock T (n 258) 380.

³⁰³ Eckes C (n 239) 280.

deference comes in the form of making the ECHR a minimum standard in EU law which is laid out in the EU Charter.³⁰⁴ Convention rights are minimums and when the CJEU is interpreting them it should consider the jurisprudence of both courts. However, the EU is also free to offer further protection and go beyond the minimum.³⁰⁵ This idea of a Convention being a basic minimum which others are free to go beyond and take further, but not go below, will be poignant in the concluding chapters and comparable to ideas on international law and global rights. The CJEU has acknowledged the rights guaranteed in the ECHR long before the EU Charter made them. As early as 1975 they confirmed the rights were protected in EU law.³⁰⁶

2.4.1.3.3.3 Conflict

Whilst *Bosphorus* shows that there is general cooperation and deference, there has not always been,³⁰⁷ and this is where two courts at the same level can create problems when they adjudicate on the same issue. In *Emesa Sugar*³⁰⁸ it was argued that Treaty arrangements of the EU in not allowing comments on the Opinions of the Advocate General breached the right to a fair hearing under the European Convention. The CJEU found that the case law of the ECtHR did not apply.³⁰⁹ This was since accepted by the ECtHR³¹⁰ but it is still suggested there has been friction between the Courts requiring a Memorandum of Understanding in 2007.³¹¹ Indeed Callewaert goes as far as to say they seek changes in each other's case law and discusses a few areas where there is still some disharmony between

³⁰⁴ European Union, *Charter of Fundamental Freedoms of the European Union (adapted)* (2010/C 83/02) (2000) Article 52(3); ECKES C (n 239) 278.

³⁰⁵ Callewaert J (n 300) 777.

³⁰⁶ Case C 36/75, *Rutili v. Ministre de l'Intérieur* [1975] ECR 32 ; Callewaert J (n 300) 769; Miller V (n 270) 3.

³⁰⁷ Case C-17/98 *Emesa Sugar* [2000] ECR I-665.

³⁰⁸ *ibid.*

³⁰⁹ *ibid.*

³¹⁰ *Kress v. France* (2001) ECHR 39594/98; see also Bradley KSC, 'Legislating in the European Union' in Barnard C, and Peers S, (ed), *European Union Law* (Oxford University Press 2014) 104.

³¹¹ Miller V (n 270) 7.

the Courts.³¹² Avoiding such disharmony and confusion in court's decisions is vital for appropriate, respected jurisprudence governments will be more inclined to follow, as will be seen in more detail in the next chapter when discussing suitable examples where there is a clear hierarchy and *stare decisis*, as opposed to inappropriate examples leading to excess litigation, confusion, and a failure to follow a court's ruling.

2.4.1.3.3.4 *Is Accession The Answer?*

This is one of the reasons many support the accession of the EU to the ECHR; because it will help create legal certainty and ensure that the Convention is applied consistently.³¹³ The cooperation that has been seen and the fact that the courts routinely refer to each other's case law has created uniformity for the most part.³¹⁴ This is not based on a duty, but on comity. Accession may create a hierarchy in the European Courts and a *stare decisis*,³¹⁵ but it would solidify the relationship, erase some concerns and create a lasting legal harmony. There is a legal difficulty requiring what Lock calls a paradigm shift in EU law if the CJEU is to be bound by the ECtHR; particularly as mentioned earlier, national courts are not required to be bound.³¹⁶ It remains to be seen about where Europe goes from here. As regards to adjudicating the right to healthcare, as mentioned, it is generally limited to environment, goods quality, freedom of movement and reimbursement of costs for the CJEU.³¹⁷ Healthcare is considered very rarely through the scope of the right to

³¹² Callewaert J (n 300) 769.

³¹³ Miller V (n 270) 10; Lock T (n 258) 381.

³¹⁴ *Pellegrin v. France* (1999) ECHR 28541/95; *Christine Goodwin v The United Kingdom* (2002) ECHR 28957/95; Lock T (n 258) 380.

³¹⁵ Lock T (n 258) 385.

³¹⁶ *ibid* 386.

³¹⁷ Case C-158/96 *Kohll v. Union des Caisses de Maladie* [1998] ECR I-1935; Case C-376/98 *Germany v Parliament and Council (Tobacco Advertising)* [2000] ECR I-8419; Case C-157/99 *Gerat Smits and Peerboom* [2001] ECR I-05473; Case C-368/98 *Vanbraekel* [2001] ECR I-5363; Case C-385/99 *Muller Faure* [2003] ECR I-4509; Case C-372/04 *Watts* [2006] ECR I-4325; Case C-466/04 *Herrera* [2006] ECR I-05341; Case C-343/09 *The*

life by the ECtHR.³¹⁸ There is a seeming reluctance to discuss the nature of a countries health care system.

This is a particularly contentious issue with courts being involved in ESC rights decision making and will be discussed in more detail in the next chapter. Dennis and Stewart argue it is necessary that ESC rights are non-justiciable³¹⁹ and Sir Thomas Bingham M. R. summed up the difficulty in 1995:

It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. . . . Difficult and agonizing judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make.³²⁰

It is suggested that the difficult nature of courts being involved in such positive rights makes the right to health particularly difficult to enforce;³²¹ it will be argued that this need not be the case. The discussion of the most successful human rights implementer across the world has been quite limited and not considered the many impacts it has via 'soft law' contributions or the multilevel systems across the EU.³²² This is because the main focus is on enforcement of existing human rights and the impact a court can and should have. This will be seen in further discussion later in the thesis.

2.5 Conclusion

Queen, on the application of Afton Chemical Limited v. Secretary of State for Transport [2010] ECR I-7027; Case C-544/10 *Deutsches Weintor eG v. Land Rheinland-Pfalz* [2012].

³¹⁸ *Osman v United Kingdom* (1998) ECHR 23452/94; *Scialaqua v. Italy* (1998) 34151/96 DR.

³¹⁹ Dennis MJ, and Stewart DP (n 116).

³²⁰ *R v Cambridge Health Authority ex parte B (Child B)* [1995] 1 WLR 898, 906.

³²¹ McHale JV, 'Fundamental rights and health care' (n 240) 312.

³²² Hervey TK, and McHale JV (n 56) 238, 252-254.

It has been important to establish that children have rights, both in theory and in practice, and subsequently discuss some of the problems associated with realising those rights. At the start of the chapter it was seen that many of the problems around children's rights are difficult to resolve and centre around the inability to effect their rights through the democratic process. Given the clear international standards and rights that were subsequently highlighted in this chapter, "[t]he attention of the international community is now turning to securing means for enforcement of those standards."³²³ Manfred Nowak has also argued that international law does not yet have effective enforcement, and that high standards and monitoring procedures without it may be counterproductive.³²⁴

Nowak subsequently proposes his interesting, drastic changes to the universal human rights system, which includes a World Court of Human Rights.³²⁵ Buergenthal recommends beginning with a much weaker, non-binding United Nations Court for Human Rights,³²⁶ which will be further discussed in 6.2.3, but it is clear that the idea of an overseeing judicial forum is appealing to many authors.³²⁷ The idea of judicial remedies for ESC rights is not new: in General Comment 14 the CESCR states that implementation of the right to health at the national level should be "based on the principles of accountability, transparency and independence of the judiciary".³²⁸ Additionally, the 1986 Limburg principles on the implementation of the

³²³ Smith RKM (n 49) 175.

³²⁴ Nowak M, 'The UN High Commissioner for Human Rights: A Link Between Decisions of Expert Monitoring Bodies and Enforcement by Political Bodies' in Bayefsky AF (ed), *The UN Human Rights Treaty System in the 21st Century* (Kluwer Law International 2000).

³²⁵ Nowak M, and Kozma J, 'A World Court of Human Rights' (2009) *Protecting Dignity: An Agenda for Human Rights - Swiss Initiative to Commemorate the 60th Anniversary of the UDHR*; see also Nowak M (n 324) 254.

³²⁶ Buergenthal T (n 185).

³²⁷ Nowak M, and Kozma J (n 325); Scheinin M, 'Towards a World Court of Human Rights' (2009) *Protecting Dignity: An Agenda for Human Rights - Swiss Initiative to Commemorate the 60th Anniversary of the UDHR*; Trechsel S, 'A World Court for Human Rights?' (2004) 1 *Northwestern Journal of International Human Rights*.

³²⁸ General Comment 14, Article 55; see also Kinney ED (n 54) 341.

covenant states that: “Legislative measures alone are not sufficient to fulfil the obligations of the Covenant. . . States Parties shall provide for effective remedies including, where appropriate, judicial remedies.”³²⁹ There are many different ways and strategies to protect, promote, and fulfil rights, but it has been suggested that the ideal way is preventive, so as to discourage and reduce the chances of violations occurring in the first place and provide a long-term solution. Knowledge that there is successful adjudication of ESC rights may provide this preventive measure as a more powerful deterrent to violation than being ‘named and shamed’.

As Tripathi *et al* argue:

Access to justice for victims, the potential punishment of perpetrators, and the reduction of impunity are all elements of this prevention. The widespread impunity that now prevails for abuses of economic and social rights, the extremely limited toolbox of legal responses, and the difficulties surrounding their justiciability are all challenges that need to be faced together if long-term solutions are to be found.³³⁰

As can be seen from the example of Europe, judicial remedies may provide a powerful way of implementing human rights, but the right to healthcare, and ESC rights generally, are not yet included in a way that will impact globally by ensuring basic minimums and adjudicating on the healthcare system of a member State. Thus it seems necessary to discuss the strongly debated question of whether ESC rights can be adjudicated by the Courts in order to complete Part A, which has focused on *exploring the problem*. In Part B, discussion then addresses the issues by seeking changes to our philosophical mindset, the structure of a court system and adjudication, and general changes to human rights implementation.

³²⁹ The Limburg Principles, 18-19; see also Kinney ED (n 54) 340.

³³⁰ Tripathi V, Hoodbhoy MO, and Rosenthal M (n 50) 267.

Chapter Three

Domestic Lessons for Enforcement of Economic, Social and Cultural Rights

This chapter aims to continue the work of chapter two which highlighted some clear problems with the enforcement of the right to healthcare and with economic, social and cultural (ESC) rights more generally. In light of these problems and the lack of effective international change highlighted at the end of the last chapter, this chapter addresses the contested issue¹ of whether the rights contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR) are justiciable. To do this, this chapter is divided into two sections. First, discussion of whether ESC rights in general can be adjudicated will be undertaken by looking at various examples of cases from around the world; many in the countries discussed in chapter one. This will look at national legal systems and domestic cases because there is not a large body of international experience utilising the ESC rights in international treaties.² Despite this, certain domestic analysis can serve as a good example as will be seen in the second section which finds an appropriate guide for the justiciability of ESC rights. The two sections serve as excellent examples for ESC rights adjudication; firstly negative, and secondly positive. It is important to learn lessons from both. It

¹ Tobin J, *The Right to Health in International Law* (Oxford University Press 2011) 202; see also Bates E, 'The United Kingdom and the International Covenant on Economic, Social and Cultural Rights' in Baderin M, and McCorquodale, R. (ed), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007).

² Leary VA, 'The Right to Health in International Human Rights Law' (1994) 1 Health and Human Rights 25, 27; see also Bates E (n 1) 283; see also *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territories* (Advisory Opinion) [2004] ICJ Rep, General List no 131; see also Chowdhury J, 'Judicial Adherence to a Minimum Core Approach to Socio-Economic Rights - A Comparative Perspective' (2009) Paper 27 Cornell Law School Inter-University Graduate Student Conference Papers 1.

will be seen that some jurisprudence is not appropriate, yet others show how ESC rights can be justiciable in a way that assuages fears about lack of specificity and a court overstepping its role within a democratic government. This then wraps up Part A and the exploration of the current position and problem of children's right to healthcare. Addressing the specific problems in this chapter will be undertaken in chapter five, where the lessons learnt here will be brought together in a framework posited as necessary for courts to follow to ensure appropriate adjudication of such rights. This will accept the use of the minimum core with the right to health, discussed previously in section 2.3.1.2, as well as an accountability for reasonableness test. It will be proposed that together these can form a framework that any court should use when adjudicating ESC rights and would serve to defeat suggestions that such rights are not justiciable.

3.1 The Justiciability of Economic, Social and Cultural Rights

The idea of justiciable ESC rights is a contentious one,³ with critics pointing to many potential problems, yet three main ones stand out. Firstly, there have been suggestions that ESC rights are idealistic goals that lack specificity and not something a court has enough detail to adjudicate on.⁴ Secondly, is the criticism of separation of powers and the independence of the court and role of democratic governments.⁵ Critics suggest it is impossible for a court to adjudicate an ESC right without overstepping into the ambit of the legislature as such decisions will

³ Ferraz OLM, 'Harming the Poor Through Social Rights Litigation: Lessons from Brazil' (2011) 89 Texas Law Review 1643; see also Tobin J (n 1) 202; see also Bates E (n 1).

⁴ Beetham D, 'What Future for Economic and Social Rights?' (1995) 43 Political Studies 41; see also Bates E (n 1).

⁵ Bates E (n 1) 282.

necessarily involve resource allocation choices seen to be exclusively within the domain of government.⁶ Section one of this chapter will address the first criticism, and section two will address the second although it is recognised that deference must be given to the third and final criticism; that implementing ESC rights is not assured even if these rights are considered justiciable. Accepting this problem from the beginning of this judicial chapter hopefully assuages criticisms of 'judicial romanticism' as it is understood a court's powers derive from the political process, of which the court is only one part.⁷ An illustration of this point can be seen from 1831 and the US Supreme Court. The Cherokee Indians were trying a new tactic as they sued the country for trying to remove them from their lands to west of the Mississippi river. Chief Justice John Marshall ruled in their favour. Despite this, President Andrew Jackson is reported to have said; "Well, John Marshall has made his ruling. *Now let him enforce it!*"⁸ The phrase is debated, but what is known is that Andrew Jackson exercised his executive power as Commander-in-Chief and despite the ruling, forcibly marched the Cherokee Indians to new lands west of the Mississippi on what is known as the 'trail of tears'.⁹ In an eerily accurate prediction of such potential problems, Alexander Hamilton, founding father of the United States, commented in his famous *Federalist Papers*, that the judiciary would have "no influence over either the sword or the purse . . . It may truly be said to have

⁶ *ibid* 284; importantly Bates himself does not agree with these criticisms and argues that there is no evidence this need to be the case. In fact, the evidence points to the courts being trustworthy enough to act responsibly and provide good protection of the rights. Lord Lester and O'Conneide aren't so certain. See Lord Lester of Herne Hill QC and O'Conneide C, 'The Effective Protection of Socio-Economic Rights' in Ghai Y, and Cottrell J, (ed), *Economic, Social and Cultural Rights in Practice: The Role of Judges in Implementing Economic, Social and Cultural Rights* (Interights 2004).

⁷ Reisman WM, 'The Constitutional Crisis in the United Nations' (1993) 87 *The American Journal of International Law* 83, 94.

⁸ Remini RV, *Andrew Jackson and the Course of American Freedom 1822-1832*, vol 2 (Harper and Row Publishers 1981) 276; citing Greeley H, *The American Conflict: A History of the Great Rebellion of the United States of America, 1860-1864*, vol 1 (Hartford 1865) 106, citing George N. Briggs, Representative from Massachusetts.

⁹ Young H, 'Remembering Genocide within Our Borders: Trail of Tears and US Museum Culture' in Rivera-Servera RH, and Young H, (ed), *Performance in the Borderlands* (Performance Interventions, Palgrave Macmillan 2011).

neither force nor will, but merely judgment; and must ultimately depend upon the aid of the executive arm even for the efficacy of its judgments.”¹⁰ The importance of this will be returned to later, but the first issue of whether ESC rights can be justiciable at all will be addressed by looking at various cases from the countries selected in the earlier comparison because of their constitutional right to healthcare.

3.1.1 India

3.1.1.1 Extending Directive Principles Through the Court

India is one of the best known examples of a country that has established a justiciable right to health and has done so without the right being within the enforceable section of the constitution. The right to health is part of the Directive Principles of State Policy (DPSP).¹¹ Article 37 states this Part “shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws.”¹² Despite this clear limitation it is the case of *Keshavananda Bharati v State of Kerala*¹³ that is considered to have opened the floodgates for the Indian judiciary to establish an enforceable right to health.¹⁴ Here the Indian Supreme Court restricted the right of the government to amend the

¹⁰ Hamilton A, 'The Judiciary will always be least dangerous to the political rights of the Constitution' *The Federalist No. 78* (New York, June 1788).

¹¹ This is an increasing trend that state policy is featuring increasingly in constitutional texts, see Fassbender B, 'The United Nations Charter As Constitution of The International Community' (1998) 36 *Columbia Journal of Transnational Law* 529, 536.

¹² Government of India, Ministry of Law and Justice, *The Constitution of India*, modified up to 1st December 2007.

¹³ (1973) 4 SCC 225.

¹⁴ Byrne I, 'Making the Right to Health a Reality: Legal Strategies for Effective Implementation' (Commonwealth Law Conference, 2005); see also Muralidhar S, 'Justiciability of ESC Rights - the Indian Experience' Circle of Rights Economic, Social and Cultural Rights Activism: A Training Resource International Human Rights Internship Program 2000
<<http://www1.umn.edu/humanrts/edumat/IHRIP/circle/justiciability.htm#30t>>last viewed 03/04/2015.

constitution in any way they see fit, ruling that they cannot amend the “basic structure or essential features of the constitution.”¹⁵ The court also discussed within this context the DPSP, recognising their importance to the enforceable fundamental rights and their complementary nature.¹⁶ In this case one Judge said: “In building up a just social order it is sometimes imperative that the fundamental rights should be subordinated to the directive principles”,¹⁷ which led to the belief that they were complimentary with “neither part being superior to the other.”¹⁸ It is suggested that after this case in 1973 and the state of emergency declared between 1975 and 1977, the perception of the judiciary in India changed concerning “its role in the working of the Constitution.”¹⁹ Between 1975 and 1977, large scale rights violations occurred across India and the post-emergency period led to political realignment and a weak government that did not last long.²⁰ The judiciary stepped in and promoted the public-interest litigation (PIL) movement which, acknowledging that the majority of the population could not access the justice system, relaxed procedural rules so much so that even “writ petitions could be submitted on a postcard.”²¹ The post emergency period allowed the judiciary to become actively involved in the protection of those who were deprived of their most basic constitutional rights. PIL was the tool the Court used by disregarding the traditional requirements of *locus standi*.²² This was clearly seen in *Sunil Batra v Delhi Administration*²³ where a prisoner who was being tortured wrote a letter to the

¹⁵ *Keshavananda Bharati v State of Kerala* (1973) 4 SCC 225 para 1615.

¹⁶ *Keshavananda Bharati v State of Kerala* (1973) 4 SCC 225 para 1707; see also Muralidhar S ‘Justiciability of ESC Rights’ (n 14).

¹⁷ *Keshavananda Bharati v State of Kerala* (1973) 4 SCC 225 para 879.

¹⁸ *State of Kerala v. N.M.Thomas* (1976) 2 SCC 310 para 367; see also Muralidhar S, ‘Justiciability of ESC Rights’ (n 14); see also Muralidhar S, ‘Implementation of Court Orders in the Area of Economic, Social and Cultural Rights: An Overview of the Experience of the Indian Judiciary’ (First South Asian Regional Judicial Colloquium on Access to Justice, 2002).

¹⁹ Muralidhar S, ‘Justiciability of ESC Rights’ (n 14).

²⁰ *ibid.*

²¹ Byrne I (n 14) 16; see also Muralidhar S, ‘Justiciability of ESC Rights’ (n 14).

²² Andhyarujina TR, ‘The unique judicial activism of the Supreme Court of India’ (2014) 130 Law Quarterly Review 53; Muralidhar S, ‘Justiciability of ESC Rights’ (n 14).

²³ (1978) 4 SCC 494.

Supreme Court, which was taken up as a petition and the court made orders for humane treatment. Progressively, the court began to expand its protection and interpretation beyond the basic rights guaranteed in the Constitution. As more destitute individuals were able to come before the courts, it was inevitable that the courts would have to decide if they were going to protect them or not. PIL has been critical in bringing ESC rights within the scope of the judiciary,²⁴ and from this point, despite their non-justiciability in the Constitution, the Supreme Court took it upon itself to make some of the principles in the DPSP equivalent to the protected civil and political rights and has done this mainly “through the application of an expansive definition of the right to life.”²⁵

One palpable example of this expansion was in 1992 in *Mohini Jain v. State of Karnataka*,²⁶ which focused on the right to education, the expense of higher education and the charging of capitation fees for private colleges.²⁷ In finding the fees illegal, the Supreme Court held that “[t]he right to education flows directly from the right to life. The right to life under Article 21 and the dignity of an individual cannot be assured unless it is accompanied by the right to education.”²⁸ The extension of the right to life was one argument used, but the court also determined the interdependence of the DPSP and fundamental rights, stating: “These principles [DPSPs] have to be read into the fundamental rights. Both are supplementary to each other.”²⁹ This argument was reiterated just a year later in a case that was brought by private colleges challenging State legislation regulating the capitation fees. In *Unni Krishnan, J. P. v State of Andhra Pradesh*³⁰ the court went a little

²⁴ Muralidhar S, 'Implementation of Court Orders in the Area of Economic, Social and Cultural Rights' (n 18).

²⁵ Byrne I (n 14) 16; see also Lord Lester of Herne Hill QC and O'Cinneide C (n 6) 19.

²⁶ (1992) 3 SCC 666.

²⁷ Capitation fees are fees that are not advertised in the prospectus, charged by an institution after admission has been accepted.

²⁸ *Mohini Jain v. State of Karnataka* (1992) 3 SCC 666, 8.

²⁹ *ibid* 7.

³⁰ (1993) 1 SCC 645.

further in clarifying its thinking behind the interdependence of the two parts to the Constitution. Using the same two arguments of the extension of the right to life and the importance and interdependency of Article 41, the right to education in the DPSP, the court held that Article 41 informed the content of the right to life, but that not every DPSP would inform what the right meant. The court decided that in this instance only Articles 41, 45 and 46 would determine the parameters of the right.³¹

So the court established that the DPSP can inform the content of a right that has been found via extension of fundamental, enforceable rights in the Constitution. With this in mind the court ruled that children have a fundamental right to free education up to the age of 14, and beyond that it is subject to economic capacity.³² The impact of this case can further be seen by the 86th Constitutional Amendment mentioned in chapter one; the addition of Article 21A, the right to primary education for 6 to 14 year olds within Part III of the Constitution.³³ However given that the court had already established the justiciable right to education, such an amendment by the government seems strange unless it was purposefully designed to show acceptance of judicial enforcement and oversight for this right, and whilst doing so indicate that the government did not accept further extension by the judiciary of other DPSP within the ambit of Article 21 and attempting to reinforce the separation of powers doctrine.

3.1.1.2 *Samity: A justiciable right to health*

³¹ *Unni Krishnan JP v State of Andhra Pradesh* (1993) 1 SCC 645 paras 48-50.

³² *Unni Krishnan JP v State of Andhra Pradesh* (1993) 1 SCC 645; see also Kothari J, 'Social Rights and the Indian Constitution' (2004) 2 Law, Social Justice and Global Development Journal ; see also Muralidhar S, 'Justiciability of ESC Rights' (n 14).

³³ Chowdhury R, "'The Road Less Travelled': Article 21A and the Fundamental Right to Primary Education in India' (2010) 2 Indian Journal of Constitutional Law 24.

If this was the hidden intent of the government it did not work, as the right to health has also been included in this expansion. The key case is *Paschim Banga Khet Mazdoor Samity and Ors v State of West Bengal*³⁴ (Samity). Here a labourer suffered serious head injuries and a brain haemorrhage and was taken to eight State medical institutions over 14 hours. He was refused access to all of them either because of a lack of beds or lack of necessary facilities for his treatment. He was eventually admitted to a private hospital which cost Rs. 17,000.³⁵ The court was very quick to establish the one important question it would use to decide the case: is the non-availability of treatment a denial of a fundamental right under Article 21?³⁶

Paragraph 9 of the decision leaves no room for doubt that they believe the right to health is an integral part of the right to life, and that this right had clearly been violated in such circumstances. The argument is based on reading the Constitution as envisaging a welfare State, which in turn establishes a government obligation to provide adequate medical facilities. The court held that failing the obligations of a welfare State would violate the right to life.³⁷

The court then, crucially, went beyond merely finding a violation to the right to health via the right to life and ordering redress, by proceeding to issue directions to the government on the exact facilities they had to provide. The court listened to an Enquiry Committee appointed by the state government and to other experts and “learned Counsel”³⁸ to make further specific orders to the state government before ruling that these orders should apply to all other states within India as well as the national government.³⁹ These ordered facilities were expansive, including a better communication set up, better ambulance services, and the upgrading of hospitals at

³⁴ (1996) 4 SCC 37.

³⁵ *Paschim Banga Khet Mazdoor Samity and Ors v State of West Bengal* (1996) 4 SCC 37 para 2.

³⁶ *ibid* para 4.

³⁷ *ibid* para 9.

³⁸ *ibid* para 14.

³⁹ *ibid* paras 16-17.

district and sub-division level.⁴⁰ The court was focusing on the “essential minimum” of the right to health, which seems like some acceptance of the minimum core established by the CESCR.⁴¹ The court admitted that such expansive direction will require financial resources but merely commented in response that constitutional obligations cannot be ignored. There was no discussion or consideration of the financial implications or a possible resource allocation prerogative of the government and the obligation stands irrespective of any financial constraints.⁴² It is possible that the court believed the right to life, and via extension the right to emergency treatment, is so fundamental and a minimum core obligation of the government that it goes beyond resource constraints, but this discussion was not undertaken. All that was said was “[w]hatever is necessary for this purpose has to be done.”⁴³ This expansive direction is where many criticisms of the Indian Supreme Court lie. *Samity* is one example, however the court also started to get involved in ordering petrol pump sites, rules of conduct for public authorities, control of automobile emissions, parking charges and many more trifling matters that should not be considered by any judiciary.⁴⁴

3.1.1.3 Criticisms of the Court

The Indian Supreme Court has faced many criticisms of illegitimately extending its jurisdiction into areas regarded as the prerogative of a democratic government through “overt judicial activism”⁴⁵ leading to “continued non-implementation . . .

⁴⁰ *ibid* para 15; see also Byrne I (n 14).

⁴¹ Chowdhury J (n 2).

⁴² *ibid*.

⁴³ *Paschim Banga Khet Mazdoor Samity and Ors v State of West Bengal* (1996) 4 SCC 37 para 16.

⁴⁴ For a good overview of the myriad of cases the court has decided on such minor matters see Andhyarujina TR (n 22).

⁴⁵ Kothari J (n 32).

undermining the court's authority."⁴⁶ Tobin highlights how India stands alone with such expansive judicial activism creating a precedent for an expansive interpretation and going beyond what is reasonable in other jurisdictions.⁴⁷ The court however has remained stoic, arguing that it is filling the void of inadequate branches of government and that the importance of the policy decisions outweighs a strict adherence to separation of powers.⁴⁸ It is suggested courts cannot decide on such issues seen as the role of the legislative and executive branches without usurping power.⁴⁹ The undermining of the court's authority⁵⁰ raises questions about the legitimacy of the court and demonstrates a lack of respect for their decisions. One of the main problems causing this is the structure of the court, which hears thousands of cases, meaning it is impossible to keep track, leading to inconsistent decisions from different benches and a breakdown of the system of precedent.⁵¹ However elsewhere it is suggested that there has been a general acquiescence by the government to such judicial activism.⁵² There have doubtless been some cases where the government has disagreed with the court to such an extent as to pass legislation, or the cabinet has had to assert an ordinance, so that the order of the court is rendered void.⁵³ The problem of non-implementation of judicial orders is a concern for the legitimacy of the court and shows a lack of respect for the decisions of the court echoing Andrew Jackson's "now let him enforce it!"

⁴⁶ Muralidhar S, 'Implementation of Court Orders in the Area of Economic, Social and Cultural Rights' (n 18); see also Kothari J (n 32).

⁴⁷ Tobin J (n 1) 187.

⁴⁸ Kothari J (n 32); see also Byrne I (n 14).

⁴⁹ Lord Lester of Herne Hill QC and O'Cinneide C (n 6) 19.

⁵⁰ Muralidhar S 'Justiciability of ESC Rights' (n 14); see also Kothari J (n 32) and Byrne (n 14) 11.

⁵¹ Robinson N, 'A Quantitative Analysis of the Indian Supreme Court's Workload' (2013) 10 *Journal of Empirical Legal Studies* 570; the Supreme Court's workload continues to increase disproportionately to that of lower courts, the opposite of what may be expected and a clear indication that precedential value in decisions is being lost. The Court has multiple benches of often just two judges.

⁵² Andhyarujina TR (n 22) 65.

⁵³ See *Golak Nath v State of Punjab* (1967) 2 SCR 762; *Shiv Sagar Tiwari v Union of India* (1996) 6 SCC 530.

In 2014, the Indian Parliament passed the Judicial Appointments Commission Bill. This is in response to the judiciary seizing the power from the executive to appoint judges and further illustrates the tension between the two branches in India. In 1993, the courts reversed the position in the Constitution that the president, after consultation with the Chief Justice, would appoint judges to the superior courts.⁵⁴ This was interpreted as concurrence, so the Chief Justice made recommendations to the President, who had limited scope to disagree. This was then changed again in an advisory opinion, that the Chief Justice together with some senior colleagues, known as a 'collegium' would recommend names to the President, who is then bound by the decision.⁵⁵ This is another example of the court grabbing power that was not bestowed upon them and is the main reason for the long awaited Bill passed in 2014 which just awaits ratification and assenting by the state legislature and the President. The Bill will set up a national judicial commission to appoint senior judges which will remove the power solely from the courts.

Despite this clear tension however, it is obvious that India now has a justiciable right to healthcare and has made moves to enforce ESC rights through the courts using an imaginative interpretation of the right to life. It is suggested however, that adopting such expansive interpretations in order to enforce such rights will not be the best method for international law.⁵⁶ Tobin points out that given the expansion of the right to life and the lack of an enforceable right to healthcare within the Indian Constitution, "the automatic transferability of comparative case law is problematic and these cases arguably reveal more about the scope of civil and political rights *within a particular jurisdiction*, than the justiciability of the right to health in international law."⁵⁷ The former UN Special Rapporteur on the right to health has

⁵⁴ *Supreme Court Advocate on Record Association v Union of India* (1993) 4 SCC 441.

⁵⁵ *Special Reference No. 1 of 1998, Re:* (1998) 7 SCC 739.

⁵⁶ Tobin J (n 1) 187-188, 204.

⁵⁷ *ibid* 204.

used the Samity case to argue “that there are health related rights that give rise to some immediate obligations that are not subject to resource availability.”⁵⁸ Tobin replies that Samity does not provide such evidence when international law does not mention emergency care and highlights the need for progressive realisation.⁵⁹

I agree partially with Tobin, that the Indian cases do not provide the best model for international human rights law enforcement, but as will be seen later, I support elements of the right to health being beyond the availability of resources. Hunt argues this point and states that when resources are insufficient “it is incumbent upon those in a position to assist to provide international assistance and cooperation that will enable the Government to meet its immediate obligations.”⁶⁰ This point will be further discussed in chapter six. India it seems provides some very mixed results with PIL also leading to access to the courts for those who would otherwise have been ignored and an engagement of discussion on the fulfilment of their fundamental rights.

3.1.2 Brazil

Brazil serves as an example that has a justiciable right to healthcare but has not had to create India’s extension of the right to life to do so. As seen in 1.2.2, Brazil has the right to health in its Constitution and subsequently created a universal healthcare system known as the SUS. Added to the knowledge that there is successful litigation on the right to healthcare in Brazil, it may be thought to be an excellent example for other countries as well as international law. Brazil has also

⁵⁸ Hunt P, *Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled "Human Rights Council": Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt* (2007) para 67.

⁵⁹ Tobin J (n 1) 204.

⁶⁰ Hunt P (n 58) para 67.

established a priority for a child's right to healthcare, accepting the increased vulnerability of children and need to ensure their rights are not subordinated. The Superior Court of Justice has stated that it is a constitutional norm that children's rights have absolute priority most especially with a right to healthcare.⁶¹ This sounds promising yet litigation in Brazil is not without some major problems.

3.1.2.1 Inequity in Court Access

One of the problems of the SUS is the inequities in access to health care services. The poor have much less access to the care they need than those who are wealthy, and this problem, is actually exacerbated by the nature of Brazil's healthcare litigation.⁶² Ferraz explains;

[T]here is instead a high concentration of right-to-health litigation in the richest states, cities, and districts of Brazil. . . . access to courts and lawyers is beyond the means and reach of most poor Brazilians.⁶³

This exacerbation is partly because there is no public-interest litigation (PIL) system as seen in India,⁶⁴ so plaintiffs are often relatively wealthy people.⁶⁵ Cases are not often brought by the poorest that may need State funded medicines the most. This is a common problem with universal healthcare programs that may be ill thought-out

⁶¹ Nolan A, 'The Child's Right to Health and the Courts' in Harrington J, and Stuttford M, (ed), *Global Health and Human Rights: Legal and philosophical perspectives* (Routledge 2010) 146; Langford M, 'Domestic Adjudication and Economic, Social and Cultural Rights: A Socio-Legal Review' (2011) 6 International Journal on Human Rights 91, 105.

⁶² Ferraz OLM, 'The Right to Health in the Courts of Brazil: Worsening Health Inequities?' (2009) 11 Health and Human Rights; see also Prado MM, 'The Debatable Role of Courts in Brazil's Health Care System: Does Litigation Harm or Help?' (2013) 41 Journal of Law, Medicine and Ethics 124 .

⁶³ Ferraz OLM, 'Harming the Poor Through Social Rights Litigation' (n 3) 1662; see also Brinks DM, and Forbath W, 'Commentary: Social and Economic Rights in Latin America' (2011) 89 Texas Law Review 1943, 1946.

⁶⁴ Byrne I (n 14) 16; see also Muralidhar S, 'Justiciability of ESC Rights' (n 14).

⁶⁵ Wolff J, *The Human Right to Health* (Amnesty International Global Ethics Series, First edn, W. W. Norton & Company, Inc 2012) 36.

because they counterproductively increase healthcare inequality and increase spending on the richest who have greater access to services.⁶⁶

3.1.2.2 Interpretation

Many problems are also caused by the jurisprudence of the Brazilian Court and the specific way they have interpreted the right to health. It is considered a right of all individuals to have all of their health needs satisfied with the very best treatment, irrespective of cost.⁶⁷ Failure to consider the limited resources is only one problem of the litigation in Brazil, with another being that collective complaints are almost never heard. Cases are individual and concern the provision of curative medicines to be enjoyed individually.⁶⁸ Ferraz points out that in Brazil “the right to health is an individual entitlement to the satisfaction of one’s health needs with the most advanced treatment available, irrespective of costs.”⁶⁹ Tobin agrees and adds support that “[s]uch an approach is not only unsustainable because of its drain on Brazil’s limited resources, but it also skews the benefits of the right to health to those who have access to the courts.”⁷⁰ Any such comprehensive program in a developing country, whilst promising, is likely to raise concerns of long-term affordability and sustainability.⁷¹ The reasoning of the courts in accepting such arguments has been called ‘syllogistic reasoning’⁷² because they follow the clear pattern needed for a syllogism. The argument is simple: the Constitution guarantees a right to health for everyone; this individual has a medical need requiring certain treatment; therefore they are entitled to that treatment. It is said that “all that a

⁶⁶ Lagomarsino G, Garabrant A, Adyas A, Muga R, and Otoo N, 'Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia' (2012) 380 *The Lancet* 933, 940.

⁶⁷ Ferraz OLM, 'The Right to Health in the Courts of Brazil' (n 62); see also Prado MM (n 62); see also Tobin J (n 1) 208.

⁶⁸ Ferraz OLM, 'The Right to Health in the Courts of Brazil' (n 62) 35.

⁶⁹ *ibid* 34.

⁷⁰ Tobin J (n 1) 208.

⁷¹ Lagomarsino G, and others (n 66) 940.

⁷² Prado MM (n 62) 130.

claimant must do to win his or her case under this interpretation is to prove that he or she has an unsatisfied health need as documented by a doctor's prescription."⁷³

3.1.2.3 Over-Litigation

Brazil is a civil law country therefore without the rule of *stare decisis* found in common law systems. Thus, one court decision does not affect change to all in a similar position and many similar if not identical cases have been decided.⁷⁴ Interestingly, none of the common law countries in South America have recognised a right to health in their Constitution.⁷⁵ The litigation in Brazil is thus made even more problematic by a large increase in the number of cases. Rio de Janeiro went from just 1 claim on such a case in 1991 to 2,245 in 2005, with federal courts also seeing large increases. The *Superior Tribunal de Justiça* (STJ), the second highest court in the country, went from 2 to 672 cases between 2001 and 2004.⁷⁶ This may sound rather promising in that the right to health is being enforced by the courts in a clear, consistent and strong way. However the cost of such litigation must be considered and unfortunately "[j]udges by and large do not engage in any form of substantive cost or economic impact analysis of their decisions".⁷⁷ The number of successful litigations is very high, estimated at 90% in lower courts and 100% in the Supreme Court when an individual asserts the need for a particular health service.⁷⁸

There is thus a large negative impact of all this combined:

The high rates of success, combined with the increase in litigation, means that a significant volume of resources allocated to the health care system are used to pay for

⁷³ Ferraz OLM, 'The Right to Health in the Courts of Brazil' (n 62) 35.

⁷⁴ Ferraz OLM, 'Harming the Poor Through Social Rights Litigation' (n 3) 1656.

⁷⁵ Leary VA (n 2) 34 suggests this is due to the influence of the US Constitution, which contains no ESC rights.

⁷⁶ Prado MM (n 62) 125.

⁷⁷ Hoffman FF, and Bentes RNM, 'Accountability for Social and Economic Rights in Brazil' in Gauri V, and Brinks DM, (ed), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press 2008) 139.

⁷⁸ Prado MM (n 62) 125.

judicially mandated medication and treatment. . . . litigation allocates resources originally intended to treat a large number of people to an expensive . . . treatment that may benefit just a small group, regardless of the relative wealth of the plaintiffs.⁷⁹

The outcome of all of this has been a sharp increase in federal spending on judicially granted medicines. Ferraz highlights that in 2008 São Paulo was ordered to spend approximately R\$400 million to purchase expensive drugs for 35,000 claimants.⁸⁰ He then goes on to present the problem powerfully: “This is roughly the same level of resources that the federal Ministry of Health has recently announced will be invested in a program of vaccination against pneumococcal bacteria to cover all 3.2 million children born every year in Brazil.”⁸¹ The overall federal spending on medicines ordered by the courts has also increased from R\$188,000 in 2003, to R\$26 million in just the first half of 2007.⁸² With this large increase in spending being ordered by most courts adhering to any litigant with a prescription, it seems Ferraz is right to state that resources are being diverted away from those who would benefit most to those who can access the courts.⁸³

Thus it seems Brazil's courts indirectly make resource allocation decisions which are often considered to be the prerogative of government. One way of justifying such direction and decision making by a court is a ring-fenced core element of rights protected by the Constitution that the government therefore has no power to change. This maybe the view point of Brazil's courts in their interpretation of the Constitutional right to healthcare however, it seems clear that even if this was the initial intention of the courts jurisprudence, it has moved far beyond this core protected element into the dangerous territory of the government having less and

⁷⁹ *ibid* 126.

⁸⁰ This equates to R\$11,428 per claimant able to access the court, as compared to the average spending of R\$3,189 per capita total health expenditure. Figures from Organization for Economic Co-operation and Development, *Health at a Glance 2013: OECD Indicators*, (OECD Publishing 2013) 155.

⁸¹ Ferraz OLM, 'The Right to Health in the Courts of Brazil' (n 62) 41.

⁸² Hoffman FF, and Bentes RNM (n 77) 140; see also Prado MM (n 62) 126.

⁸³ Ferraz OLM, 'The Right to Health in the Courts of Brazil' (n 62) 41.

less money to spend on health programmes it has highlighted as important because of the benefits granted to the successful litigants in court. Ferraz argues that the cumulative effect is retrogressive and it will be very hard for Brazil to change now it has started down this jurisprudential path.⁸⁴ Thus Brazil's health jurisprudence exacerbates health inequities and over steps into the role of a democratic government.

3.1.3 Interim Concluding Remarks

Both India and Brazil have a justiciable right to healthcare, but finding support for the justiciability of the right to health is not the same as showing the appropriate way to adjudicate it. India has established this justiciable right via an interesting expansion of the right to life, but has also done so for many other rights from the DPSP. This means the courts have decided which rights in the DPSP should become justiciable and have taken it upon themselves to amend the Constitution. This may be in response to inadequate and inert governments, yet it is clearly not an ideal model to follow. In Brazil, the Constitution establishes a justiciable right to healthcare, but it is the simplistic syllogistic reasoning of this right that leads to problems. A right in the Constitution, and then an individual having a medical need, should not necessarily require the State to provide that need regardless of cost. This, combined with the individual litigation and lack of collective complaints or class actions, leads to decisions with vast resource implications that deviate money from other programmes and is then spent on those who can afford to put themselves in court. So there is a difference between having a justiciable right to healthcare, and an appropriate way to adjudicate this right. More appropriate models for a

⁸⁴ Ferraz OLM, 'Harming the Poor Through Social Rights Litigation' (n 3).

framework that should be followed by domestic and international courts when seeking to enforce a child's right to healthcare are now looked at.

3.2 The appropriate justiciability of ESC rights

For the appropriate justiciability of ESC rights, constitutional recognition would seem to be required to at least minimise the possibility of such imaginative interpretation of the Indian Supreme Court, as well as an established jurisprudence which shows some deference to the resource allocation powers usually the preserve of government, so as to avoid the problems seen in Brazil. Constitutional recognition or 'codification'⁸⁵ should prevent imaginative interpretation and also presents the rights in a similar way to the international treaties and conventions. This idea of international human rights being compared to constitutional law has been mentioned briefly above and will be further discussed in the final chapter. To reiterate, this is the reason why adjudication of the right to health is analysed in countries that provide the right within a written Constitution and not the UK or US for example, the UK having no written constitution and the US having no right to healthcare. Such adjudication must be carried out in an appropriate manner as befitting the rule of law. Deference to government is an acceptance of the separation of powers doctrine which often includes the resource allocation decisions being the prerogative of the elected branches. The CESCR has roundly rejected the notion that ESC rights are not justiciable at all, and there is plenty of evidence to

⁸⁵ Byrne I (n 14); see also Easley CE, Marks SP, and Morgan Jr RE, 'The Challenge and Place of International Human Rights in Public Health' (2001) 91 American Journal of Public Health 1922, 1923.

support this position.⁸⁶ It is filling this gap between poor jurisprudence and judicial overstep on one extreme and complete lack of justiciability on the other that needs to be navigated.

3.2.1 South Africa

Arguably the best known and most widely celebrated model that fits this description is South Africa, which has many ESC rights included in the Constitution, yet there have been very few significant cases decided by the South African courts.⁸⁷

3.2.1.1 Establishing the Justiciability of ESC Rights

From the very beginning of post-apartheid South Africa and the 1996 Constitution, there were challenges in South Africa to a courts ability to adjudicate on ESC rights culminating in “the First Certification case”⁸⁸. Here the very inclusion of ESC rights within the Constitution was challenged before the Constitutional Court on the grounds that such inclusion was against the separation of powers doctrine because it would lead the court to making decisions, especially budgetary, that are the prerogative of the other branches of government. The court based its response on an argument already encountered above; that adjudicating ESC rights will not be different from adjudicating civil and political rights, as both sets of rights can have large budgetary impact and as the justiciability of civil and political rights is not contested, neither can the justiciability of ESC rights. The court added:

⁸⁶ Committee on Economic, Social and Cultural Rights, *General Comment No. 3 - The nature of States parties obligations* (1990) 5; see also Bates E (n 1).

⁸⁷ Byrne I (n 14) 7.

⁸⁸ *Ex parte Chairperson of the Constitutional Assembly: in re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC).

In our view it cannot be said that by including socio-economic rights within a bill of rights, a task is conferred upon the courts so different from that ordinarily conferred upon them by a bill of rights that it results in a breach of the separation of powers.⁸⁹

The court also held that, at the very least, ESC rights can have negative protection so that they are not improperly impeded.⁹⁰ Therefore it was made clear that ESC rights were justiciable and the courts jurisdiction over them was expressly acknowledged.⁹¹ Berger points out that these short arguments put an end to the debate of the justiciability of ESC rights in South Africa, but the true meaning of winning this argument can only be seen in the context of considering the cases that came after such peremptory conclusions.⁹² Four highly significant such cases will be discussed in chronological order to see how South Africa has developed its jurisprudence on ESC rights.

3.2.1.2 *Soobramoney*

The first case applies specifically to the right to healthcare and access medical treatment. The *Soobramoney*⁹³ case in 1998 and was the first instance the Constitutional Court “was asked to interpret the enforcement of a quintessentially socioeconomic right against the state”.⁹⁴ *Soobramoney* suffered from chronic renal

⁸⁹ *ibid* para 77.

⁹⁰ *ibid* para 78.

⁹¹ Ngweni C, 'The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?' 5 *Health and Human Rights* 27; see also Sandhu PK, 'A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?' (2007) 95 *California Law Review* 1151, 1174.

⁹² Berger J, 'Litigating for Social Justice in Post-Apartheid South Africa: A Focus on Health and Education' in Gauri V, and Brinks DM, (ed), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press 2008) 42.

⁹³ *Soobramoney v. Minister of Health (Kwazulu - Natal)* 1998 (1) SA 765 (CC).

⁹⁴ Ngweni C (n 91) 32; see also Davis DM, 'Adjudicating the Socio-Economic Rights in the South African Constitution: Towards 'Deference Lite'?' (2006) 22 *South African Journal on Human Rights* 301, 305; see also Sandhu PK (n 91) 1176; Wesson M, 'Reasonableness in

failure and needed kidney dialysis to survive. He petitioned the State to provide him with the necessary medical care arguing his rights under Section 27(3) of the Constitution, the right to emergency medical treatment, and the right to life in Section 11. The State had in place a policy that denied Soobramoney dialysis because he was not a candidate for a transplant and therefore did not meet the guidelines. Only 30% of patients with chronic renal failure met the guidelines for dialysis⁹⁵ and the State in its defence argued that the policy was in place because of a lack of resources.

The court ruled in favour of the State. It did not accept that chronic renal failure constituted emergency medical treatment saying section 27(3) envisaged sudden trauma not ongoing conditions and treatment. The court also dismissed the right to life argument stating that as there is a separate provision for the right to healthcare within the Constitution, the argument was unnecessary. In doing this, the court specifically referred to the *Samity* case of India and stated the differences in jurisprudence because of the specific provision in the South African Constitution.⁹⁶ The court stated that the arguments made by the appellant should have been based on sections 27(1) and (2), but then went on to rule that even on these arguments the claim would not have succeeded because the healthcare guaranteed must be within the States available resources. The court accepted the resource limits of the State, noting that it had actually over-spent on its budget,⁹⁷ and appreciated the “difficult decisions to be taken at the political level in fixing the health budget”,⁹⁸ stating they would be slow to interfere when rational decisions were taken in good faith.

Retreat? The Judgment of the South African Constitutional Court in *Mazibuko v City of Johannesburg* (2011) 11 Human Rights Law Review 390, 393.

⁹⁵ *Soobramoney v. Minister of Health (Kwazulu – Natal)* 1998 (1) SA 765 (CC) para 26.

⁹⁶ *ibid* paras 15-18.

⁹⁷ *ibid* para 24.

⁹⁸ *ibid* para 29; see also Sandhu PK (n 91) 1176.

Crucially the court did not look at the case individually and regardless of cost. The case was decided more generally and it was accepted that the decision would have an impact on all patients in Soobramoney's position which is a basic tenet of the rule of law which requires that similar cases be treated similarly⁹⁹ and therefore would have an impact on the wider State health sector. Helping Soobramoney would directly impact on someone else's healthcare.¹⁰⁰ This is a communitarian position in which individual rights are subject to the interests of the community as a whole with equity being the dominant consideration.¹⁰¹ This is also the situation seen in Venezuela.¹⁰² Sachs J, a judge in the *Soobramoney* case, later argued that if all chronic illnesses and their treatments were to be emergency situations, the effect of the health system would be enormous with no funds left for many other important areas of health care.¹⁰³ Knowing that an individual rights analysis, as in Brazil, can be dangerous and lead to problematic conclusions,¹⁰⁴ the question changed. The court was asking itself, not whether the State could afford just one more kidney dialysis patient, but many more, and thus the court assessed the appropriateness of the guidelines that restricted dialysis to those with acute renal failure. The court noted how stretched the services were, before stating:

It has not been suggested that these guidelines are unreasonable or that they were not applied fairly and rationally¹⁰⁵ . . . If everyone in the same condition as the

⁹⁹ Rawls J, *A Theory of Justice: Revised Edition* (Oxford University Press 1999) 208.

¹⁰⁰ Wolff J (n 65) 81.

¹⁰¹ da Costa Leite Borges D, 'Making sense of human rights in the context of European Union health-care policy: individualist and communitarian views' (2011) 7 *International Journal of Law in Context* 335, 336, 342 such a view is grounded in theories of social justice and the obligation to protect equal opportunity.

¹⁰² Hogerzeil HV, Samson M, and Casanova JV, *Ruling for Access: Leading court cases in developing countries on access to essential medicines as part of the fulfilment of the right to health* (World Health Organization: Department of Essential Drugs and Medicines Policy, 2004) 34-35 the courts, in allowing cases brought by individuals with regards to their right to health, have insisted that it applies to all people in the same situation, not just those who have managed to gain access to the court

¹⁰³ Sachs A, 'Social and Economic Rights: Can They Be Made Justiciable?' (2000) 53 *Southern Methodist University Law Review* 1381, 1385-1386.

¹⁰⁴ Sandhu PK (n 91) 1177, 1181.

¹⁰⁵ *Soobramoney v. Minister of Health (Kwazulu - Natal)* 1996 (1) SA 765 (CC) para 25.

appellant were to be admitted the carefully tailored programme would collapse and no one would benefit from that.¹⁰⁶

Thus, whilst regrettable, there were legitimate resource constraints on the State, and the guidelines they had therefore applied because of this were found to be reasonable. The deference to the State to decide what was best given these constraints was the beginning of an important test of reasonableness, and maintaining an important margin of appreciation which will be seen throughout the South African jurisprudence on ESC rights. Berger suggests that *Soobramoney* shows that a right to healthcare “does not impose an obligation on the state to provide everything to everyone”.¹⁰⁷ The court made this point itself acknowledging that many South Africans did not have housing, food, water or many other necessities, but the State had to manage its limited resources to do what it could.¹⁰⁸

This test of reasonableness has its roots in the English case of *Wednesbury*,¹⁰⁹ and is in actual fact the well established test of proportionality.¹¹⁰ It may look different on the surface but it is argued that the common theme of a balancing exercise between competing rights and public interests means they are the same underneath.¹¹¹ The words reasonable and proportionate, and unreasonable and disproportionate can replace each other. In fact, much of South African jurisprudence is similar to that seen in the UK with judicial review cases and the deference and margin of appreciation generally given.¹¹² This margin of appreciation is important for the UK

¹⁰⁶ *ibid* para 26.

¹⁰⁷ Berger J (n 92) 54.

¹⁰⁸ *Soobramoney v. Minister of Health (Kwazulu - Natal)* 1996 (1) SA 765 (CC) para 31.

¹⁰⁹ *Associated Provincial Picture Houses Ltd v Wednesbury Corp* [1948] 1 KB 223; [1947] 2 All ER 680; “in order for a decision of a public body/authority to come under the jurisdiction of the court, the decision would have to be so unreasonable that no reasonable authority could have reached that decision.” para 683.

¹¹⁰ Möller K, 'From constitutional to human rights: On the moral structure of international human rights' (2014) 3 Global Constitutionalism 373.

¹¹¹ *ibid*.

¹¹² See for example, *R v Cambridge Health Authority, ex parte B* [1995] 2 All ER 129 at 137, CA. *R v Sec. of State for Social Services, ex p Hincks* (1980). *R v Central Birmingham Health Authority, ex parte Walker* (1987) 3 BMLR 32; *R v Central Birmingham Health*

which, as seen in chapter one, has a very different healthcare system to Germany, but both would generally be considered to realise the right to healthcare. The similarity of jurisprudence between the UK and South Africa is not so surprising as the English courts serve as a good example, but it is more appropriate to focus on the development of a clear codified right in South African case law for eventual comparisons with the international human rights to healthcare, later in this thesis.

The difficulty associated with adjudicating ESC rights and the hardship involved with the search for appropriate jurisprudence can be demonstrated by the fact that Soobramoney died two days after this ruling.¹¹³ The court had to make this legal decision knowing a man's life was in their hands. Albie Sachs has written of the emotional nature of some of the Constitutional Courts cases, particularly describing *Soobramoney* as a "most painful case. The Court's decision could help prolong his life or else conduce to his early death."¹¹⁴ This shows the difference ESC rights justiciability can make and therefore the difficulties presented with such rights necessarily being restricted by resources.

3.2.1.3 Grootboom

The second case to come before the Constitutional Court on ESC rights shows similar elements of this difficulty despite it being the first time the court found the State in breach of its ESC rights obligations.¹¹⁵ In *Grootboom*¹¹⁶ the right in question

Authority, ex parte Collier (1988) unreported. *R v North Derbyshire Health Authority, ex parte Fisher* (1997) 38 BMLR 76. *R v West Lancashire Health Authority, ex p A, D & G* (2000) 1 WLR 977. *R (on the application of Rogers) v Swindon NHS Primary Care Trust* (2006) EWCA Civ 392. *R (on the application of Otley) v Barking and Dagenham NHS Primary Care Trust* (2007) EWHC 1927.

¹¹³ Sachs A, 'Social and Economic Rights' (n 103) 1386; see also Sandhu PK (n 91) 1177.

¹¹⁴ Sachs A, 'Social and Economic Rights' (n 103) 1385; see also Sachs A, 'The Judicial Enforcement of Socio-Economic Rights: The *Grootboom* Case' (2003) 56 Current Legal Problems 579.

¹¹⁵ Berger J (n 92) 45.

was the right to housing, guaranteed by Section 26 of the Constitution, and also Section 28 which focuses specifically on children's rights with 28(1)(c) mentioning basic shelter. They had no water, sewage or refuse disposal.¹¹⁷ The 900 respondents¹¹⁸ lived in what little space they could find on the Wallacedene sports fields, so Mrs. Grootboom and the other respondents applied to the State to provide basic temporary shelter under their Constitutional rights protected by Section 26 and 28 for the children (of this population 510 were children, 390 were adults).¹¹⁹

The High Court only found a breach of Section 28(1) (c), not of Section 26.¹²⁰ The court accepted the shortage of available housing and resources but felt the housing programmes in place were acceptable. For Section 28 however, the High Court held that the right imposed immediate obligations of basic shelter and was not dependent on resources. The High Court therefore ordered the immediate provision of basic shelter for all children, and one parent of each dependent child, under Section 28, but nothing under Section 26. On appeal the Constitutional Court found problems with this approach:

This reasoning produces an anomalous result. People who have children have a direct and enforceable right to housing under section 28(1) (c), while others who have none or whose children are adult are not entitled to housing under that section¹²¹.

The Constitutional Court accepted the overlap between Section 26 and 28, but not that this overlap meant separate rights for children and their parents that are independent of other rights in the Constitution.¹²² As the children were not in State

¹¹⁶ *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC).

¹¹⁷ *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 7.

¹¹⁸ *ibid* para 4, footnote 2.

¹¹⁹ *ibid*.

¹²⁰ *Grootboom v Oostenberg Municipality and Others* 2000 (3) BCLR 277 (C).

¹²¹ *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 71.

¹²² *ibid* para 74.

care, there was no State obligation to provide those children with shelter, and through them, their parents.¹²³ Importantly, the Constitutional Court was worried that the High Courts approach would make children a means to an end, and treat adults who had children differently in regards to their right to housing. However they did rule in the respondents' favour with regards to Section 26. Whilst stating that neither Section entitles immediate claims to shelter or housing, the Constitutional Court stated that Section 26 does impose an obligation on the State to put in place a programme that will provide relief for those desperately in need.¹²⁴ Thus, the Constitutional Court found that Section 26 imposes an obligation on the State to devise an adequate housing plan, within its available resources, that takes into account those in desperate need, and the current plan did not do this. Deference to government and the prerogative to make budgetary decisions is evident – as in the *Soobramoney* case however, there was an order for the government to adhere to but the precise allocation was for government to decide.¹²⁵

Despite this court ruling, Mrs. Irene Grootboom died homeless 8 years after this case, and a supposed 'victory', bringing once again to mind Andrew Jackson's "*let him enforce it!*" Bilchitz comments that this indicates "quite graphically that socio-economic guarantees may well amount to very little if not enforced strictly and with the necessary institutional mechanisms."¹²⁶ In *Grootboom*, the court once again considered the reasonableness of the State programme that was in place, finding it unreasonable to not consider and provide relief to those in desperate need. However, further specifics of what this unreasonableness meant and the content of the right were not ordered despite being explored by the court. There was promising

¹²³ *ibid* para 79.

¹²⁴ *ibid* para 95.

¹²⁵ *ibid* para 66.

¹²⁶ Bilchitz D, 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence' (2003) 19 *South African Journal of Human Rights* 25; see also Pillay K, 'Implementing *Grootboom*: Supervision needed' (2002) 3 *ESR Review* 13.

discussion by both courts of the UN minimum core established in General Comment 3 of the ICESCR¹²⁷ but it was decided not to use this method of specifying the content of the right. In deference to government, the court stated “[i]t is not in any event necessary to decide whether it is appropriate for a Court to determine in the first instance the minimum core of a right.”¹²⁸ However, the court did not reject the idea of a minimum core outright as some have mistakenly argued.¹²⁹ The court acknowledged that the “[m]inimum core obligation is determined generally by having regard to the needs of the most vulnerable group that is entitled to the protection of the right in question.”¹³⁰ This is similar to the finding that the current programme was in breach of Section 26 for not considering those in desperate need. However, the court did not believe it had enough information to create a minimum core itself or to define its content. It accepted that the CESCR was in a position where it could develop the content as it had gained experience over many years via extensive reports, but held that it could not because of the need to identify all the various needs and opportunities which will depend on a variety of factors such as income, unemployment, land, poverty, and rural and urban differences.¹³¹ The court stated:

All this illustrates the complexity of the task of determining a minimum core obligation for the progressive realisation of the right of access to adequate housing without having the requisite information on the needs and the opportunities for the enjoyment of this right.¹³²

The court also could not use information or reports by the Committee because South Africa had not ratified the ICESCR. It is argued in the next section that this is a missed opportunity and that a minimum core will add much needed content to

¹²⁷ *International Covenant on Economic, Social and Cultural Rights* (1966).

¹²⁸ *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 33; see also Davis DM (n 94) 307.

¹²⁹ Chowdhury J (n 2).

¹³⁰ *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 31.

¹³¹ *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 32.

¹³² *ibid.*

ESC rights which will help to meaningfully adjudicate them, something which may happen in future with South Africa's recent ratification of ICESCR.

It may be thought that South Africa has not achieved as much as might seem possible through its jurisprudence. Forman has argued that the South African "limited approach certainly misses opportunities for advancing the realization of the right, [but] it nonetheless has had a positive influence on national health policy."¹³³

Above it was suggested that the South African judicial approach is a more acceptable way to adjudicate ESC rights, especially as a framework for international courts and enforcement of international human rights law. However the cases considered so far have failed to produce promising changes, questioning their impact and surely their use as a model even if the jurisprudence seems more appropriate than India or Brazil. There is however one more case to consider, in which the Constitutional Court of South Africa used the same test of reasonableness and which shows that decisions of this court can carry meaning and lead to significant changes in the implementation of ESC rights.

3.2.1.4 Treatment Action Campaign

*Minister of Health v Treatment Action Campaign (TAC)*¹³⁴ was mentioned in chapter one because of the changes it has led to. The TAC is a powerful NGO that brought this case against the government because of the policy on the ARV drug *nevirapine* which would prevent mother to child transmission of HIV. The drug was only available at a limited number of centres which focused on research because the government questioned its safety and effectiveness as well as the connection between HIV and AIDS.¹³⁵ The TAC argued this policy was in breach of Section

¹³³ Forman L, 'Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy' (2005) 33 The Journal of Law, Medicine and Ethics 711, 715.

¹³⁴ 2002 (5) SA 721 (CC).

¹³⁵ Berger J (n 92) 55.

27(1), the right to access health care services. The government's defence was based on the need for continued research and a lack of resources to provide the drug nationally. The government argued that at the sites where *nevirapine* was available, a full comprehensive programme was used including counselling and breast-milk substitution which is why it was effective and it lacked the resources to roll this out to other hospitals. Key to defeating this argument was that *nevirapine* had been provided free of charge to South Africa for five years by Boehringer Ingelheim, and that without the full programme the drug would still save many lives.¹³⁶ Thus it was found unreasonable for the government not to provide the drug at State hospitals and the court therefore required the government "to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV."¹³⁷ The court ordered *nevirapine* be made available at other State hospitals allowing its use to prevent mother to child transmission of HIV. This is perhaps as specific as the South African Court gets with regards to directing government action. Whilst the deference to government may be consistent with separation of powers Byrne¹³⁸ argues the limited approach and lack of detail leads to problems with implementation of the courts orders "since it took several months of campaigning and lobbying by TAC and others to force the authorities to act and start supplying the drugs."¹³⁹

Since then however, as seen in chapter one, South Africa has made huge steps in the availability of ARV drugs and treatment. Other elements to enforcement of ESC rights are important, but an appropriate court judgment can serve as a powerful tool.

¹³⁶ *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 (CC) para 57.

¹³⁷ *ibid* para 135.

¹³⁸ Byrne (n 14) 10.

¹³⁹ *ibid*.

The codification of ESC rights in South Africa, considering cases with regards to collective rights and finally the deference to government making difficult resource allocation decisions, overall makes the jurisprudence of South Africa a good model for the justiciability of the right to healthcare. Tobin agrees and argues:

[T]he comparative exercise can be used to demonstrate the justiciability of the right to health in international law and in this respect two cases arising under the South African Constitution are particularly revealing.¹⁴⁰

Tobin refers to *Soobramoney* and *TAC*. Byrne however, does not see South Africa as a perfect model to follow and whilst accepting the fine line courts must walk, argues South Africa and India are on opposite sides of that line, with neither being successful; India requiring contempt of court proceedings and South Africa requiring further lobbying.¹⁴¹

Courts have a role in protecting the rights encoded in a Constitution and ensuring that these rights become tangible guarantees,¹⁴² yet this must be done with deference and constant mindfulness that they are not the elected branch of government. The South African Constitutional Court has defended its approach in the *TAC* case arguing their jurisprudence achieves an appropriate balance because their decisions are not in themselves directed at rearranging budgets.¹⁴³ Whilst South African jurisprudence is not perfect and Byrne may be right that some more assertive elements may be required, the cases still provide appropriate lessons for the justiciability of ESC rights. Specifically for children however, South African jurisprudence may present some problems. It is argued that in the *TAC* case, the Constitutional Court rendered Section 28 not directly applicable. On the face of it, as not expressly qualified, it may be assumed that Section 28 of the South African

¹⁴⁰ Tobin J (n 1) 205.

¹⁴¹ Byrne I (n 14) 11.

¹⁴² Chowdhury J (n 2).

¹⁴³ *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 (CC) para 38 emphasis added.

Constitution imposes a direct and immediate obligation on the State to ensure such rights to children, but this has not been the courts treatment in practice.¹⁴⁴ Liebenberg argues “the Court in *TAC* adhered to its reasoning in *Grootboom* and did not conclude that children had a direct, individual entitlement to basic health care services in circumstances where their parents were too poor to afford these services.”¹⁴⁵ A concurrent argument by Nolan also points out the court’s jurisprudence, in not accepting direct and immediate obligations to ensure a child’s right, ignored the text and purpose of the constitutional provision.¹⁴⁶

Despite the appropriateness of the reasonableness test used by the South African Constitutional Court, a failure to ensure a basic minimum, especially for children, under the right to health, means slightly more assertive measures should have been taken. In these cases, the court declined the use of a minimum core but left open the possibility of using it later on. One of the main reasons for not using such a measure was a lack of institutional capacity of the court to decide on an appropriate minimum for the content of the rights in question. The opportunity to add such content and demand a basic minimum arose perfectly for the court in 2010.

3.2.1.5 *Mazibuko*

In *Mazibuko v City of Johannesburg*¹⁴⁷ the Court was dealing with the right of access to sufficient water. The residents of the Phiri township, Johannesburg argued, *inter alia*, that the city’s free monthly allocation of 6 kilolitres of water per

¹⁴⁴ Nolan A, 'The Child's Right to Health and the Courts' (n 61) 145.

¹⁴⁵ Liebenberg S, 'Taking Stock: The jurisprudence on children's socio-economic rights and its implications for government policy' (2004) 5 ESR Review 2, 4-5; see also Nolan A, 'The Child's Right to Health and the Courts' (n 61) 150.

¹⁴⁶ *ibid* 151.

¹⁴⁷ 2010 (4) SA 1 (CC).

household per month was unreasonable.¹⁴⁸ The actual consumption rate was a lot higher¹⁴⁹ and the revenue generated, because of a culture of non-payment, was substantially out of proportion to the amount of water being supplied to the area yet Johannesburg Water wanted to improve the rate of payment.¹⁵⁰ The free 6 kilolitres or 25 litres per person per day, of water was seen as the sufficient amount required under section 27 (1) (b) of the Constitution.¹⁵¹ The applicants argued however that this set minimum was too low and should be 50 litres per person per day as this is the amount needed for a dignified life.¹⁵² The court held that this argument must fail for the same reasons as the minimum core failed in *Grootboom* and *TAC*. The court did not have the capacity or authority to set a minimum core, and only a reasonableness test should be used in establishing whether the government has carried out its' duty to progressively realise the basic necessities of life.¹⁵³

Expert evidence put forward and considered in the Supreme Court of Appeal decision used General Comment 15 on the ICESCR, and evidence from an affidavit from I.H. Palmer and an article by P.H. Gleick and focused on two possible minimums; one of which was 50 litres per person per day; the other stated 42 litres per person per day.¹⁵⁴ So in contrast to the previous cases, the applicants were able to produce specific international expert evidence on the minimum core content of the right to water. Unfortunately these arguments were not engaged with at all by the Constitutional Court. As the applicants accepted that the government provided the absolute minimum necessary the possible arguments down this line were

¹⁴⁸ There were many other arguments in this complex case but this will be the focus of this thesis because it most befits the minimum core jurisprudence discussion.

¹⁴⁹ Although it was unclear how much of this was due to high consumption by households or leakage through pipes that had corroded.

¹⁵⁰ *Mazibuko v City of Johannesburg* 2010 (4) SA 1 (CC) para 13.

¹⁵¹ Wesson M (n 94) 396.

¹⁵² *Mazibuko v City of Johannesburg* 2010 (4) SA 1 (CC) para 44.

¹⁵³ *ibid* para 59.

¹⁵⁴ *City of Johannesburg v L Mazibuko* (489/08) [2009] ZASCA 20 paras 17, 21, and 24; The Supreme Court of Appeal did set a minimum standard of 42 litres per person per day and ordered the city to reformulate its' water policy to one that was reasonable based on this interpretation of Section 27 (1) (b).

drastically weakened, and the applicants went too far in asking the court to define the right to water in its entirety which the court rejected completely.¹⁵⁵ A more specific challenge should have been made to the minimum of 25 litres per person per day to force the court to engage with the studies and expert evidence and consider defining a minimum core of the right. With the evidence presented it cannot be said that the court did not have the capacity, expertise or information to make a decision on a basic minimum. The court maintained that it is ordinarily inappropriate for it, as an institution, to determine what steps should be taken to realise a right and precisely what that right entails.¹⁵⁶ Whilst it can be argued that not determining the full content of the right was correct,¹⁵⁷ the court missed a chance to seriously debate the minimum content of the right and then question government with a presumption of unreasonableness¹⁵⁸ of this is not being fulfilled. Thus it is argued here that South Africa has done well establishing reasonableness and toeing the line of adjudication and separation of powers, but an opportunity was missed to add minimum core content of constitutional rights to the reasonableness test.

However, Humby and Grandbois argue that *Mazibuko* was the correct decision because of South Africa's limit resources to provide the amount of water needed.¹⁵⁹ This somewhat misses the purpose of a minimum core that *is* subject to resource constraints. It merely contends that if a minimum core is not being fulfilled serious questions have to be asked of government. If it can be justified by a lack of resources then there is no breach of the right. Ought implies can.

¹⁵⁵ *ibid* at paras 52-56.

¹⁵⁶ *Mazibuko v City of Johannesburg* 2010 (4) SA 1 (CC) para 61.

¹⁵⁷ Wesson M (n 94) 399.

¹⁵⁸ Liebenberg S, 'The Value of Human Dignity in Interpreting Socio-Economic Rights' (2005) 21 South African Journal of Human Rights 1.

¹⁵⁹ Humby T, and Grandbois M, 'The Human Right to Water in South Africa and the Mazibuko Decisions' (2010) 51 Les Cahiers de Droit 521.

3.2.2 Columbia

Fortunately, whilst South Africa provides us with an example of one part of appropriate ESC rights jurisprudence framework, the test of reasonableness, the other aspect with regards to the minimum core and direct entitlements for children can be found in the example of the Colombian Constitutional Court.¹⁶⁰ The first of two important cases was in 1998 and focused on children's access to vaccines.¹⁶¹ Indeed Columbia is promising for children's rights because in a way similar to Brazil, which established the priority of child's rights as a constitutional norm, the Colombian Constitution explicitly states in Article 44 that children have the right to health and that "[t]he rights of children prevail over the rights of others."¹⁶²

3.2.2.1 SU-225/98

Case SU-225/98 on a child's right to healthcare services was brought by the parents of 418 children in Bogotá. It was argued that these children were particularly vulnerable and at high risk because of their living conditions and because the parents could not afford to meet the costs of the necessary vaccines to prevent meningitis to these children, thus violating their constitutional rights. The Constitutional Court agreed¹⁶³ accepting such basic care as part of the minimum content of the right to health. The Court also established immediate application of a

¹⁶⁰ Nolan A, 'The Child's Right to Health and the Courts' (n 61) 151.

¹⁶¹ *Sentencia SU-225/98* Dr Eduardo Cifuentes Muñoz (Corte Constitucional de Colombia); see Nolan A, 'The Child's Right to Health and the Courts' (n 61) 151.

¹⁶² Constitución Política De Colombia (1991); Artículo 44. Son derechos fundamentales de los niños: la vida, la integridad física, la salud y la seguridad social . . . Los derechos de los niños prevalecen sobre los derechos de los demás.

¹⁶³ *Sentencia SU-225/98* Dr Eduardo Cifuentes Muñoz (Corte Constitucional de Colombia) Fundamentos para 35.

minimum core beyond politics and decisions of representatives.¹⁶⁴ In exercising an appropriate amount of discretion, the Court concluded “that *only* the essential content of the right can be directly applied by the judge, while it is legislature which must define the full scope of the right.”¹⁶⁵

Thus the Court found that the vaccination was part of the minimum core and subject to immediate application thus the failure to provide it was a breach of the right. This essential content being immediate entitlements, yet allowing deference to the government to further the scope of the right to health, is the jurisprudence of Columbia further developed in the next case. Decided 10 years later by the same court, it would seem to address the problems seen in Brazil of a flood of litigation due to directly enforceable rights and easy access to the courts. Nolan argues that failure to make the right a direct claim for children risks allowing the right to be meaningless but acknowledges the risk of such a position to a flood of litigation like that seen in Brazil.¹⁶⁶

3.2.2.2 T-760/08

In 2008 the Colombian Constitutional Court made a landmark decision that completely changed the country’s health policy.¹⁶⁷ Columbia accepts individual claims for rights much like Brazil via *tutela*’s (protection writs) which, similarly to the

¹⁶⁴ *Sentencia SU-225/98* Dr Eduardo Cifuentes Muñoz (Corte Constitucional de Colombia) Fundamentos para 4; “Los derechos fundamentales son aquellos que se encuentran reconocidos - directa o indirectamente - en el texto constitucional como derechos subjetivos de aplicación inmediata. En otras palabras, se trata de derechos de tal magnitud para el orden constitucional, que su vigencia no puede depender de decisiones políticas de los representantes de las mayorías.” Fundamental rights are those that are recognised - directly or indirectly – as rights in the constitutional text are subject to immediate application. In other words, rights to constitutional order are of such magnitude, that its validity cannot depend on political decisions of the representatives of the majority.

¹⁶⁵ Nolan A, 'The Child's Right to Health and the Courts' (n 61) 151.

¹⁶⁶ *ibid* 149.

¹⁶⁷ *Sentencia No. T-760 de 2008* J. Magister Manuel José Cepeda Espinosa (Corte Constitucional de Colombia); Chowdhury J (n 2).

Public-Interest Litigation of India, has enhanced access to courts by ensuring limited procedural requirements. Much like Brazil, this led to high amounts of litigation¹⁶⁸ with a similar success rate of approximately 80% of *tutelas* being granted in order to resolve the individual case before the court.¹⁶⁹ In the case of T-760, the Constitutional Court brought together 22 *tutelas* to illustrate the structural and systemic problems in the health system that had led to overuse of *tutelas*. Whilst resolving these 22 cases the court called for a complete systemic transformation because the government had not established a way of guaranteeing the right to health without recourse to the *tutela*.¹⁷⁰ In directing this transformation the court reiterated its own previously established jurisdiction on the enforcement of the right to health and importantly reiterated its jurisprudence on the minimum core obligations of the State. In Columbia there was a two-tier system of health benefits: the contributory regime (*Plan Obligatorio de Salud* or POS) for those earning twice the minimum wage, and the subsidised regime (*Plan Obligatorio de Salud Subsidiado* or POSS) for those earning less, which also provides significantly less benefits of the POS.¹⁷¹ They were generally successful as before 1993, 24% of the

¹⁶⁸ Gianella-Malca C, Gloppen S, and Fosse E, 'Giving Effect to Children's Right to Health in Colombia? Analysing the Implementation of Court Decisions Ordering Health System Reform' (2013) 5 Journal of Human Rights Practice 153, 167 where it is highlighted that in 2008 alone more than 140,000 right to health claims were taken to the courts. This dropped to 94,500 in 2010.

¹⁶⁹ Yamin AE, and Parra-Vera O, 'How do courts set health policy? The case of the Colombian Constitutional Court.' (2009) 6 PLOS Medicine e1000032; see *Sentencia No. T-760 de 2008* J. Magister Manuel José Cepeda Espinosa (Corte Constitucional de Colombia) at 6, "la adopción de órdenes encaminadas únicamente a resolver los casos concretos es insuficiente ya que, además de que las mismas situaciones se siguen presentando reiteradamente, el número de tutelas para acceder a servicios de salud tiene una sólida tendencia a crecer". The adoption of orders directed only to resolve individual cases is insufficient because, in addition to the same situations occurring repeatedly, the number of *tutelas* to access health services has a strong tendency to grow.

¹⁷⁰ Yamin AE, and Parra-Vera O (n 169).

¹⁷¹ POS included approximately 60% more services than the subsidised scheme POSS; see Gianella-Malca C, Gloppen S, and Fosse E (n 168) 157; see also Giedion U, and Villar Uribe M, 'Colombia's Universal Health Insurance System' (2009) 28 Health Affairs 853; This system is based on Law 100 of 1993 which created Empresas Promotoras de Salud ((EPS) Health Promoting Entities) that are either public, private or mixed to offer health insurance under one of the two regimes.

population had health insurance, and in 2007 this was above 80%.¹⁷² The benefits provided in these systems have been interpreted by the court as defining the minimum core of the right to health.¹⁷³

In 2008, the court reiterated this jurisprudence but went further in calling for specific changes to the plans themselves. “The judgment seeks progressive realisation of universal coverage by 2010, with compliance deadlines in 2008 and 2009.”¹⁷⁴ As part of this universal coverage, unification of the POS and POSS systems was ordered, as the minimum content was not being fulfilled in the subsidised regime. It was also reaffirmed that these systems constitute the minimum core content of the right to health which is immediately enforceable and more urgent in the case of children.¹⁷⁵

It has been suggested that several cases in Columbia have explicitly embraced the minimum core content of ESC rights,¹⁷⁶ with the aim of reducing unnecessary

¹⁷² Giedion U, and Villar Uribe M (n 171) 855.

¹⁷³ Yamin AE, and Parra-Vera O (n 169).

¹⁷⁴ *ibid.*

¹⁷⁵ *Sentencia No. T-760 de 2008* J. Magister Manuel José Cepeda Espinosa (Corte Constitucional de Colombia) at paras 6.1.1.1.1 and 6.1.2.1.2; “[A]ctualmente existe una violación de la obligación constitucional de cumplimiento progresivo a cargo del Estado consistente en unificar los planes obligatorios de beneficios, para garantizar el derecho a la salud en condiciones de equidad. Si bien se trata de una obligación de cumplimiento progresivo, actualmente el Estado desconoce el mínimo grado de cumplimiento de la misma puesto que no ha adoptado un programa, con su respectivo cronograma, para avanzar en la unificación de los planes de beneficios. . . . La necesidad de unificar los planes de beneficios es aún más imperiosa en el caso de los niños y las niñas ya que, como se señaló en esta providencia (*ver sección 4.5.*), la Constitución los reconoce como sujetos de especial protección y consagra de manera autónoma su derecho fundamental a la salud (art. 44, CP).” There currently exists a violation of the constitutional obligation of progressive compliance [realisation] by the State consisting in the unification of the obligatory benefit plans, to guarantee the right to health on the condition of equity. While it is an obligation of progressive compliance [realisation], currently the State disregards the minimum degree of compliance with it as it has not adopted a program, with their respective schedule, to advance the unification of the benefit plans. . . . The need to unify benefit plans is even more imperative in the case of children because, as noted in this decision (*see section 4.5.*), the Constitution recognises them as subjects of special protection and independently safeguards their fundamental right to health (art. 44, Political Constitution).

¹⁷⁶ Chowdhury J (n 2).

litigation via the *tutela*.¹⁷⁷ Importantly the court did not defer entirely to the government on the content of the right once these orders had been made. The court explicitly adopted the CESCR's minimum core and the definition of the right to health given by General Comment 14.¹⁷⁸ The court reiterated in its ruling the immediately enforceable nature of the minimum core, whilst accepting the progressive realisation of other elements of the right to health subject to resource constraints.¹⁷⁹

3.2.3 Guaranteeing the Rights of the Child

Columbia is of particular importance for the rights of the child. In 2010, 56% of children were from households considered poor, which meant, before T-760/08, they could only gain access to the more limited POS-S health plan.¹⁸⁰ As noted, the court focused on the special protection given to children by the constitution and gave a specific order, order 21, that child POS should be unified as a matter of highest priority by October 2009.¹⁸¹ Of course, such judgments, whilst very promising, are not a panacea and guarantor of a substantial improvement in healthcare. As predicted by Hamilton and epitomised by Jackson, courts have a vital role, but how effective their role and decisions actually are, is decided by the executive and legislative branches. There have been suggestions that children from poor families still face barriers to accessing those services found in the more

¹⁷⁷ Olaya MA, 'The right to health as a fundamental and judicially enforceable right in Colombia' (2009) 10 ESR Review 16, 16.

¹⁷⁸ *Sentencia No. T-760 de 2008* J. Magister Manuel José Cepeda Espinosa (Corte Constitucional de Colombia) Segundo Anexo.

¹⁷⁹ Olaya MA (n 177) 17.

¹⁸⁰ Gianella-Malca C, Gloppen S, and Fosse E (n 168) 158.

¹⁸¹ *Sentencia No. T-760 de 2008* J. Magister Manuel José Cepeda Espinosa (Corte Constitucional de Colombia) Decisión; Resuelve: Vigésimo primero.- Ordenar; see also Gianella-Malca C, Gloppen S, and Fosse E (n 168) 164.

substantial POS, and these are often administrative, only adding to the disappointment.¹⁸²

3.2.4 Concluding Remarks

When a breach of children's rights is found, then appropriate adjudication and orders are required such as those seen in Columbia and South Africa. The specific orders of the Columbian Constitutional Court of restructuring and the immediate implementation of a minimum core may be thought to overstep the division of powers in a democratic State and lead to the pitfalls seen in India or Brazil, but some commentators have suggested the structural approach taken avoids these problems.¹⁸³ Yamin and Parra-Vera point out that "the Court does not assume it knows best what benefits should be included under the POS/POSS, nor the precise ethical grounds for making these determinations."¹⁸⁴ Thus the court avoids the specifics, deferring to government to make those decisions as to detail, but instead decides to order government to make those decisions in line with its international obligations under General Comment 14.¹⁸⁵ This goes to show, in contrast to South Africa, how a minimum core content of the right to health established in international law can be used in constitutional courts. South Africa focused on a test of reasonableness, whether the policies of government were understandable given the circumstances, whereas Columbia focused on ensuring government protected the basic minimum of the right to health, but deferred to government to decide the specific details. It is argued here that both of these types of jurisprudence on the

¹⁸² Gianella-Malca C, Gloppen S, and Fosse E (n 168) 168.

¹⁸³ Yamin AE, and Parra-Vera O (n 169); see also Gianella-Malca C, Gloppen S, and Fosse E (n 167) 163.

¹⁸⁴ Yamin AE, and Parra-Vera O (n 169).

¹⁸⁵ *Sentencia No. T-760 de 2008* J. Magister Manuel José Cepeda Espinosa (Corte Constitucional de Colombia) Segundo Anexo.

right to health provide lessons for the enforcement, implementation, and justiciability of ESC rights in international law. These two approaches will be amalgamated in the next part to form a jurisprudential framework that could avoid many of the pitfalls seen on both sides of the fine line courts have to walk. These two courts show that a courts general role to make governments accountable, can be extended to fundamental ESC rights.¹⁸⁶

¹⁸⁶ Bates E (n 1) 298-299.

Part B

Addressing the Problem

Part B now seeks to address the problems raised and explored in Part A and by doing so, will answer directly the fundamental, single research question of this thesis: can we find a way to convince everyone of a child's right to healthcare, and, if so, can we find ways of ensuring it through better enforcement? By directly addressing the two parts of that question, even the most minimal moral obligations of the State will be found to contain a child's right to healthcare; and better implementation and enforcement of international human rights law will be proposed with specific suggestions of change.

The focus for the philosophical arguments at the start of this Part of the thesis is the most ardent, 'right-wing' Republican views in the United States, which firmly believes healthcare is a commodity to be bought on the open-market and that government has no place infringing freedom by spending taxes on the healthcare of others. It seems certain that such individuals would remain completely unconvinced by such theories as the capabilities approach and so to answer the first research question of Part B, a more minimal, conservative theory of justice, which seeks to argue the very basic principles a State must have in order to be considered just, such as John Rawls' *Theory of Justice*, might be more persuasive. Therefore if a right to healthcare can be found through such a theory, it could go a long way to changing the mind-set of people opposed to the idea of healthcare as a State obligation. The problem of children within such a theory needs to be addressed in order to establish their position, especially given some of the confusion in the literature. This is undertaken and clarified before moving the theory of justice forward and applying it globally. This is done in opposition to John Rawls himself,

but it has been widely argued that his own extension of his theory is contradictory, and that actually the moral arguments used in the *Theory of Justice* naturally make a child's right to healthcare a global as well as a State obligation, in beginning to answer the second research question as to whether the general thesis arguments can be globalised. If this moral argument is accepted then there is a clear deficit in the current system, as seen in Part A, and therefore discussion in this part finishes with suggestions as to how this can be done. This is the aim of the second section of chapter five, which brings together the lessons learnt in chapter three in order to suggest an appropriate way to adjudicate the right to healthcare on a global scale. Chapter five focuses on globalising the main ideas in this thesis; Rawls' moral underpinning requiring a minimum standard of children's healthcare; and the effective implementation and enforcement of a child's right to healthcare via effective and respected adjudication. This then moves discussion onto the final chapter, which focuses on how these lofty goals may be achieved in direct answer to the final research question of how the global application of the ideas would look in practice.. From discussing a World Court of Human Rights, to rearranging the finances of the World Bank and the IMF, the focus is clear in demanding change if we are to realise and effectively implement and enforce a child's right to healthcare in international law.

Chapter Four

Justice and the Role of the State

The thesis now turns to more philosophical discussion of the role and obligations of any State that considers itself just and will use the famous work of John Rawls as its paradigm. It will discuss the hypothetical exercise Rawls' proposes as a major deviation from traditional social contract theories in order to establish the governing principles for a just society. In discussing the impact of Rawls' theory, it will be found to include healthcare with the work of Norman Daniels largely being followed. Daniels argues convincingly that the principle of equality of opportunity means protecting health just as much as it means providing education (which Rawls himself argues),¹ and therefore Daniels successfully extends Rawls' theory to include a State obligation to provide healthcare. This extension through the second principle² is especially poignant for children who require even more opportunities,³ and a necessary part of the opportunity to be healthy is the provision of healthcare. There remains no right to health as there can be no guarantee that someone will be healthy, but the opportunity must be equal. This necessitates equal access to quality healthcare services.

¹ Daniels N, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008) 61.

² Social and economic inequalities are to satisfy two conditions: first, they are to be attached to offices and positions open to all under conditions of fair equality of opportunity; and second, they are to be to the greatest benefit of the least-advantaged members of society (the difference principle) in Rawls J, (edited by Kelly E) *Justice as Fairness: A Restatement* (The Belknap Press of Harvard University Press 2001) 42-43.

³ Archard D, 'The Moral and Political Status of Children' (2006) 13 Public Policy Research 6; see also Feinberg J, 'The Child's Right to an Open Future' in Aiken W, and La Follette H, (ed), *Whose Child?* (Rowman & Littlefield 1980) 124-153 where it is argued that we have an obligation to protect children from having important choices made about them until they can decide for themselves. This can be extended to include opportunities and it being our responsibility and duty to not restrict their opportunities until they have a chance to decide what they want to do with their lives.

After discussion of this aspect of a theory of justice, the difficult challenge of incorporating children within it will be explored. As a form of social contract theory, John Rawls imagines rational adults, who are ignorant of personal knowledge, developing principles of justice, and at first sight children seem to be absent from this process and not contractors themselves. The aim is to show that the State still has obligations towards children in accordance with the basic principles of justice.

Starting from the premise that one of the most fundamental and universally accepted obligations of the State is to ensure a just and fair society, this chapter begins with discussion outlining John Rawls' theory of justice as fairness. Such an approach may be questioned if the aim is to ground a right to healthcare, yet it will be shown, and has been widely accepted from a human rights perspective, that "health is a matter of justice".⁴

Rights can merely be considered as "bawling upon paper"⁵ without philosophical justification. Thus, it is inappropriate to jump straight to the word rights and expect persuasive resolutions of distributive justice.⁶ "Rights are not moral fruits that spring up from bare earth, fully ripened, without cultivation. Rather, we may claim a right to health or health care only if it can be harvested from an acceptable general theory of distributive justice".⁷ This explains the Rawlsian starting point and the use of a theory of distributive justice. Whilst not a full acceptance of Rawls, the influence of this theory,⁸ as well as its comparatively minimalist principles to other theories that provide similar justification for the State to provide healthcare to all children, explain

⁴ Yamin AE, 'Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care' (2008) 10 Health and Human Rights 45, 46.

⁵ Sen A, 'Human Rights and Capabilities' (2005) 6 Journal of Human Development 151, 152 asserting a description by Jeremy Bentham.

⁶ Yamin AE (n 4) 50.

⁷ Daniels N, *Just Health* (n 1) 15.

⁸ Fassbender states that Rawls' theory has led to a complete revival of the almost forgotten contractualism, see Fassbender B, 'The United Nations Charter As Constitution of The International Community' (1998) 36 Columbia Journal of Transnational Law 529, 559.

why this is the chosen groundwork. As one of the main opponents of Rawls, who does submit a more minimal theory, has admitted, “[p]olitical philosophy now must either work within Rawls’ theory or explain why not.”⁹ Rawls’ theory is considered the most minimal that can find a right to healthcare and also can be appropriately applied to society.¹⁰

The work of Rawls used in this chapter, applies his theory as it stands, without need for amendment or drastic extension, and will establish that children have a moral right to healthcare in any society, of any size, that can be considered just, which in turn has an obligation to provide it. This powerful jurisprudential grounding of a child’s right to healthcare then allows for more pragmatic discussion on what has been, and can be, done to fulfil this right. For now, the thesis returns to outlining the minimal theory of justice to argue that if a child’s right to healthcare can be found even on such a limited theory of what any just society must provide, the conclusions are surely more powerful than on more elaborative ones that require much greater justification for the obligation.¹¹

⁹ Nozick R, *Anarchy, State, and Utopia* (Blackwell 1974) 183.

¹⁰ Nozick’s entitlement theory has many flaws and fails to include many palpable inequalities and wrongs as a matter of justice. More on the reasons for not accepting Nozick will be discussed later in section 4.2.4.3 and footnotes 11 and 122 specifically.

¹¹ Of course it is well known that one of the most minimal theories of distributive justice is entitlement theory by Robert Nozick, where Nozick believes that the State should limit itself to very narrow functions of protection as any other obligations will violate rights. For redistribution of goods, consent is the only condition that concerns Nozicks, leading to many of its criticisms as a theory. It is not discussed at length here because whilst it is more minimal than Rawls it has no chance of finding a child’s right to healthcare within it, but equally because by its very nature it is a flawed theory for today’s society. Nozick does not, like Rawls, purport a hypothetical exercise to imagine justice, but instead views States justification, provided they are minimal, on their so-called ‘immaculate conception’. This, for Nozick, is arising out of a free-market anarchy. Critics have pointed out that this has never happened. So the argument goes that Nozick should become an anarchist and wait for today’s States to collapse and hope something along his theory re-emerges afterwards in order to justify any existing States. Because of its’ heavy critics and impossibility to justify any obligation of healthcare, Nozick’s theory will not be discussed at any length. See, Nozick R (n 9); Rothbard MN ‘Robert Nozick and the Immaculate Conception of the State.’ (1997) 1 *Journal of Libertarian Studies* 45; Schaefer DL ‘Procedural Versus Substantive Justice: Rawls and Nozick.’ (2007) 24 *Social Philosophy and Policy* 164.

4.1 A Just Society and the Obligations of the State

John Rawls' theory of justice argues for basic, minimal, principles that should govern a just and fair society.¹² Rawls argues that this basic structure of society and how institutions distribute rights is the primary subject of justice.¹³ Rawls is concerned with the institutions of a society and *not* the justice of individual actions, thus he argues for different principles which, if adhered to by the various institutions, would ensure a just and fair society. These ground rules would be chosen in advance by some fair procedure and Rawls explains the name for this basic concept of the theory; 'justice as fairness'.¹⁴ The term "conveys the idea that the principles of justice are agreed to in an initial situation that is fair",¹⁵ not that justice and fairness are the same.

4.1.1 The Veil of Ignorance

Rawls himself successfully circumvents critics who disagree with the pragmatics of his theory by making his social contract a hypothetical exercise rather than a

¹² Rawls J, *A Theory of Justice: Revised Edition* (Oxford University Press 1999) 153-160. One of the main aims of Rawls theory was to provide a viable alternative to utilitarianism and throughout his theory of justice Rawls makes constant arguments against it which many authors find appealing. For example Feinberg finds Rawls "entirely convincing" in stating that "justice as analysed by utilitarians endorses arrangements as "just" which are plainly contrary to our natural shared convictions." See Feinberg J, 'Justice, Fairness and Rationality' (1972) 81 The Yale Law Journal 1004, 1006. Nussbaum agrees stating "utilitarianism can tolerate a result in which the total is good enough, but where some individuals suffer extremely acute levels of deprivation, whether of resources or of liberty." Nussbaum MC, 'Capabilities and Human Rights' (1997) 66 Fordham Law Review 273, 281. Barry however fails to see the usefulness of this suggesting utilitarianism is so widely defeated by similar arguments Rawls is flogging a dead horse. See, Barry, B. *The Liberal Theory of Justice: A Critical Examination of the Principle Doctrines in a Theory of Justice by John Rawls*. (Oxford University Press 1973) 7.

¹³ Rawls J, *A Theory of Justice* (n 12) 6.

¹⁴ *ibid* 10.

¹⁵ *ibid* 11.

historical reality. He emphasises this point by making his “single most important departure from *traditional* social contract theory”,¹⁶ the ‘veil of ignorance’.¹⁷ The purpose of this veil is to make the contractors ignorant of who they are, their desires, skills, and so on, so that when deciding the principles there is no way the contractors can manipulate them to their own advantage. Rawls describes at length the ignorance contractors will have in the original position:

[N]o one knows his place in society, his class position or social status; nor does he know his fortune in the distribution of natural assets and abilities, his intelligence and strength, and the like. Nor, again, does anyone know his conception of the good, the particulars of his rational plan of life, or even the special features of his psychology such as aversion to risk or liability to optimism or pessimism. More than this, I assume that the parties do not know the particular circumstances of their own society. That is, they do not know its economic or political situation, or the level of civilization and culture it has been able to achieve. The persons in the original position have no information as to which generation they belong.¹⁸

In this way it can be seen how Rawls creates his initial situation that is fair,¹⁹ because he removes all knowledge of all morally arbitrary attributes an individual may possess. Rawls argues that contractors should be put in to this original position, or behind the ‘veil of ignorance’, and only when this is done can fair principles of justice be reached that should be followed in the contractors’ society. This philosophically favoured interpretation of the hypothetical original position ensures that agreements reached will be fair and the principles can be appealed to in any disputes over justice once the veil is lifted.²⁰ These principles cannot be to any individual’s advantage, partly because of each individual’s lack of knowledge, but

¹⁶ McBride WL, ‘Social Theory *Sub Specie Aeternitatis*: A New Perspective’ (1972) 81 The Yale Law Journal 980, 993 emphasis added.

¹⁷ Barry B (n 12) 13-14, Barry contends it is not specifically the idea of a veil of ignorance that is distinctive about Rawls but rather the motivational postulates that are distinctive; what is ruled in or out by Rawls’ veil of ignorance.

¹⁸ Rawls J, *A Theory of Justice* (n 12) 118.

¹⁹ Rawls J, *A Theory of Justice* (n 12) 11.

²⁰ Nagel T, ‘Rawls on Justice’ in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy, Stanford University Press 1989) 6.

also because these principles have to be agreed to unanimously by all the contractors.²¹ Thus these principles will also be minimal as the original position is “designed to reconcile by reason . . . what all parties to the discussion hold in common.”²² No inappropriate reasoning is allowed behind the veil and in this way the veil of ignorance is thick, as opposed to thin, which means any and all undue influences will not exist behind the veil. A thin veil may allow some knowledge over who the individuals are or the society they will enter, whereas a thick veil removes all such knowledge. Rawls defends this by, in essence, appealing to minimalism which is also one of the main reasons I invoke Rawls’ conception of justice. A thick veil of ignorance could be a weakness because it does not allow the use of comprehensive doctrines, which are of great importance, yet Rawls defends this by essentially saying that is the whole point of his theory. In a society there will be many diverse comprehensive doctrines which may all be reasonable, and the objective of the political conception of justice is to be able to gain the support of all citizens, even those with differing doctrines. Thus Rawls is seeking for that overlapping consensus which all citizens can agree to.

Putting peoples’ comprehensive doctrines behind a veil of ignorance enables us to find a political conception of justice that can be the focus of an overlapping consensus and thereby serve as a public basis of justification in a society marked by the fact of reasonable pluralism.²³

Given the hypothetical exercise that this contract is, and given the lack of knowledge each contractor has, Rawls is right in suggesting that each individual who undertakes such an exercise will decide on the same principles. The individuals in the original position must all be rational beings, and with their ignorance about themselves, it is argued that this means all contractors are so similar as to render

²¹ Hampton, J, 'Contracts and Choices: Does Rawls Have a Social Contract Theory?' (1980) 77 *The Journal of Philosophy* 315, 316.

²² Rawls J, *A Theory of Justice* (n 12) 509.

²³ Rawls J, *The Law of Peoples with "The Idea of Public Reason Revisited"* (Harvard University Press 1999) 32.

the need for consensus and placing more than one party in the original position, obsolete.²⁴ Rawls, whilst not explicitly saying so, would seem to admit part of this.²⁵ The contractors are different people but they do not know *how* they are different. So consensus is required even though they will be convinced by the same arguments because the knowledge that consensus is required, and thus the publicity of arguments, will influence the principles proposed and chosen. The principles are based on what all the contractors have in common, which is a large part of their justification,²⁶ and contrasts with the idea of consensus being obsolete because the contractors are so similar, that is rational beings with no personal knowledge.²⁷ The principles must be chosen as a public conception and thus the rationale behind the principles must be available to everyone and acceptable to all members of society. So the contractors know they must all agree, even though they are all influenced in the same way, and it is argued by Rawls that this knowledge is what makes the contract and requirement for consensus valuable and not redundant.²⁸

Rawls argues that the principles that can be agreed to will be a small list, and much smaller than the list of things contractors may rationally choose. Thus he is stating a difference between the class of things contractors would want, and the principles

²⁴ Hampton J (n 21).

²⁵ Rawls J, *A Theory of Justice* (n 12) 120.

²⁶ *ibid* 508.

²⁷ Pogge T, *Realizing Rawls* (Cornell University Press 1989) 270-1; Lyons has pointed out that this is a commonly used coherence argument to show that the principles chosen are based on moral data that is held in common, seeking an overlapping consensus, and they are the most possible congruent to our considered moral judgments. He goes on however to state that this is not an actual justification for the principles because they could be arbitrary or accidental, so more is needed. See, Lyons D, 'Nature and Soundness of the Contract and Coherence Arguments' in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy, Stanford University Press 1989) 146-147.

²⁸ Rawls J, 'Reply to Alexander and Musgrave' (1974) 88 *The Quarterly Journal of Economics* 633, 651 emphasis added "[T]he agreement in the original position is to be unanimous and yet everyone is situated so that all are willing to adopt the same principles. Why, then, the need for an agreement when there are no differences to negotiate? The answer is that reaching a unanimous agreement without a binding vote is *not* the same thing as everyone's arriving at the same choice, or forming the same intention. . . the agreement that results is different from the choice everyone would otherwise have made. It is only because the contract condition governs the parties' reflections from the outset that their willingness to acknowledge the same principles can give rise to the illusion that this condition is redundant."

they would agree to, to govern their society. These principles would be minimal and universal because of knowledge of the contract, the necessary unanimous agreement, and the knowledge that they must be obeyed once the 'veil of ignorance' is lifted.²⁹ Broadly speaking these principles are, firstly, equal basic liberty, and secondly, that inequalities are acceptable only if the worst off are better off and there is equality of opportunity.

Rawls suggests that any rational person can, at any time, undergo this hypothetical exercise and pull the veil over themselves. Rawls' argument is that if we do that, and then try to form principles of justice for our society, we will inevitably come up with the same basic and minimal principles he argues for. As Ronald Dworkin explains:

Rawls does not suppose that any group ever entered into a social contract of the sort he describes. He argues only that *if* a group of rational men *did* find themselves in the predicament of the original position, they would contract for the two principles. . . Rawls supposes, for example, that his men would inevitably choose conservative principles because this would be the only rational choice, in their ignorance, for self-interested men to make.³⁰

With no information about ourselves, we would be forced to approach the principles of justice from a "disinterested vantage point".³¹ The aim of the 'veil of ignorance' is to "nullify the effects of specific contingencies which put men at odds and tempt them to exploit social and natural circumstances to their own advantage."³² Moreover, "[t]he agreement or contract is explicitly a hypothetical one, expressing what free and equal rational persons *would* choose for their conception of justice."³³

²⁹ *ibid* 651-652.

³⁰ Dworkin R, 'The Original Position' (1973) 40 The University of Chicago Law Review 500 , 501, 504 emphasis added; see also Rawls J, *A Theory of Justice* (n 12) 19.

³¹ Feinberg J (n 12) 1014.

³² Rawls J, *A Theory of Justice* (n 12) 118.

³³ Brock DW, 'The Theory of Justice' (1973) 40 The University of Chicago Law Review 486 , 489 emphasis in original.

The 'veil of ignorance' is also the paragon of another concept Rawls has established in his theory of justice; that of pure procedural justice.³⁴ The idea behind pure procedural justice "is to design the social system so that the outcome is just whatever it happens to be, at least so long as it is within a certain range."³⁵ Rawls illustrates this using gambling and engaging in fair bets. As long as the bets are fair and entered into voluntarily, then the outcome, whatever it is, is fair. Pure procedural justice "obtains when there is no independent criterion for the right result: instead there is a correct or fair procedure such that the outcome is likewise correct or fair, whatever it is, provided that the procedure has been properly followed".³⁶ It is the background circumstances that ensure a fair procedure. This is also what ensures that the principles designed in the original position are *the* principles of justice.³⁷ So it can be seen how creating the 'veil of ignorance' in the way that Rawls does is designed to be the first and most fundamental example of pure procedural justice, and ensure that the outcomes from the original position will be fair and just.

4.1.2 The Principles of Justice

Despite this hypothetical veil of ignorance as an example of pure procedural justice to ensure fair and just principles, Rawls does not leave his theory there for us to

³⁴ Rawls J, *A Theory of Justice* (n 12) 104.

³⁵ *ibid* 74.

³⁶ *ibid* 75.

³⁷ Lyons D (n 27) 157, Barry suggests this reasoning from Rawls is not strong enough for us to believe the principles chosen would necessarily be the principles of justice. Barry is not convinced that we would accept the principles as the principles of justice simply because of the limited knowledge of the contractors but instead we would need to be convinced by the motivational factors leading to the principles. One major flaw Barry has is that the example he uses to make his point adds detail to the original position, that of race, and therefore is immediately self-defeating. In trying to show the veil of ignorance will not guarantee the principles of justice Barry disobeys the rules of the original position as Rawls designs it. Barry's struggle to think of an example that follows the rules, demonstrates the idea that the lack of knowledge allowed behind the veil is more than enough justification that the principles chosen will be the principles of justice. Outside the contract, there can be no objective basis for principles of social justice. See, Barry B (n 12) 15-17.

think about. Instead he offers his own extensive arguments on what basic, minimum, uncontested principles would logically be chosen by the rational beings in the original position.³⁸ As mentioned, the requirement of publicity and the thought that will occur to the contractors that the principles they decide must be acceptable to everyone, will lead to the minimal principles Rawls suggests.

The final formulation Rawls presents of the two principles is;

- (a) Each person has the same inalienable claim to a fully adequate scheme of equal basic liberties, which scheme is compatible with the same scheme of liberties for all; and
- (b) Social and economic inequalities are to satisfy two conditions: first, they are to be attached to offices and positions open to all under conditions of fair equality of opportunity; and second, they are to be to the greatest benefit of the least-advantaged members of society (the difference principle).³⁹

The relationship between the original position and the principles of justice is a deductive one,⁴⁰ and Rawls uses many arguments to defend his position that these are the two principles that would be chosen in the original position. One strategy used is that this conception of justice would be seen as better than the alternatives, particularly utilitarianism, as it makes the position of the worst off better than other

³⁸ Rawls J, *A Theory of Justice* (n 12) 508-9.

³⁹ Rawls J, (edited by Kelly E). *Justice as Fairness* (n 2) 42-43; Rawls J, *Political Liberalism: Expanded Edition* (Columbia Classics in Philosophy, Columbia University Press 2005) 5-6; Rawls J, *A Theory of Justice* (n 12) 266, where the wording is structured quite differently.

⁴⁰ Barry B (n 12) 11, 116-121. Barry however does not agree with Rawls' deductive reasoning that the rational beings would choose principles that would ensure as much distribution of these primary goods as possible. Barry's argument is that there are plenty of things it is rational for us to want, or want more of, other things being equal, but it does not necessarily follow that it is rational for everyone to have them or us to want everyone to have them. He suggests people would want to be powerful but they also want to be free from the power of others. However, if the contractors realise the antithesis they will leave decisions on power until after the veil has been lifted. Deciding who receives power is not really a decision for behind the veil, and the necessary individual power to control your life is guaranteed by the rights already considered a primary social good. It may also be argued that Barry is wrong in thinking that everyone will want more power and it is rational to want more. Not everyone likes the idea of being prime minister. Some people will find their interests, once they leave the original position, lie in something completely different, and just want to get on and enjoy their lives. But in order to do that, they will need basic rights and liberties, along with opportunities, income and wealth.

viable options.⁴¹ Another general argument Rawls uses, is a focus on the consensus required making the two principles the only feasible proposal. He argues the parties “can rely on one another to adhere to the principles adopted”⁴² since everyone’s good is affirmed, there are no consequences that would be seen as unacceptable, and no one is asked to accept less liberty or a loss of freedom, as may be the case in some alternatives such as utilitarianism.⁴³ This conception of justice therefore publicly expresses respect for each individual in a scheme of mutual benefit, adding to the generation of its own support and thus stability as everyone’s good is affirmed, and enhances the argument that these principles are the best feasible proposal.⁴⁴

A final argument Rawls uses is an appeal to intuition. Hare argues that Rawls would not call himself an intuitionist but acknowledges we cannot avoid all appeals to intuition.⁴⁵ Hare criticises the theoretical structure as tailored to fit Rawls’ own subjective, intuitionist position, whereas Rawls believes that he is arguing objectively for the principles that would be chosen if people are put in such a position and think long and hard enough about it.⁴⁶ However, one basic notion of intuition will be used to ensure that the principles chosen do not disagree with our most basic notions of justice, or common sense convictions,⁴⁷ and thus by going back and forth with this we will eventually reach what Rawls calls reflective equilibrium. The starting point for a reflective equilibrium is that anyone has the capacity to reason and a sense of justice providing them with certain convictions all of which could be rational and reasonable. However the need for consensus

⁴¹ Rawls J, *A Theory of Justice* (n 12) 153.

⁴² *ibid* 153.

⁴³ *ibid* 154-5.

⁴⁴ *ibid* 154-6.

⁴⁵ Hare RM, 'Rawls' Theory of Justice' in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy, Stanford University Press 1989) 83-84.

⁴⁶ *ibid* 82.

⁴⁷ Barry B (n 12) 12.

requires these separate convictions to be analysed and carefully considered as some will need to be withdrawn. Our considered judgments duly adjusted will lead to matching principles; this adjustment is reflective equilibrium. As the contractors have the same public conception of political justice they can all think through with considered judgements from various perspectives and at this stage they reach full, general, reflective equilibrium.⁴⁸ But by removing the individual conception of the good from the contractors, the intuition could be said to come from what the parties will agree, and in this way there is no reason to suppose that Rawls is wrong to suggest his intuition would not fit everyone else's in the same position.

Rawls also suggests that in the original position the parties will agree there are certain things called 'primary social goods'.⁴⁹ These "are things which it is supposed a rational man wants whatever else he wants"⁵⁰ and regardless of his life plan because more of them would always be preferred over less. They are designed to be universal and timeless,⁵¹ although he admits they may be added to should it prove necessary.⁵² The primary social goods Rawls proposes, "in broad categories, are rights, liberties, and opportunities, and income and wealth"⁵³ as well as self-respect which Rawls discusses later.⁵⁴ Questions have been raised about how one might weigh important factors against these primary social goods, such as health status,⁵⁵ and Rawls' response, that his theory is an ideal theory envisaging an ideal

⁴⁸ Rawls J, (edited by Kelly E). *Justice as Fairness* (n 2) 29-32.

⁴⁹ See Nagel T (n 20) 8, who does not believe Rawls' construction of the original position accomplishes the unanimity he believes it does. Nagel believes there must be a conception of the good within the theory in order to justify the restriction of choice in the original position.

⁵⁰ Rawls J, *A Theory of Justice* (n 12) 79.

⁵¹ MacDougall DR, 'Rawls and the Refusal of Medical Treatment to Children' (2010) 35 *Journal of Medicine and Philosophy* 130, 137.

⁵² Rawls J, *Political Liberalism* (n 39) 181.

⁵³ Rawls J, *A Theory of Justice* (n 12) 79; Rawls J, *Political Liberalism* (n 39) 181, where Rawls goes adds slightly to the list adding freedom of movement and free choice of occupation for example; see also Rawls J, 'Social unity and primary goods' in Sen A, and Williams, B. (ed), *Utilitarianism and beyond* (Cambridge University Press 1982) 162.

⁵⁴ Rawls J, *A Theory of Justice* (n 12) 386-391.

⁵⁵ Arrow KJ, 'Some Ordinalist-Utilitarian Notes on Rawls' Theory of Justice' (1973) 70 *Journal of Philosophy* 245.

human condition, is far from a satisfactory one.⁵⁶ Fortunately, Barry has stated that we can see the primary social goods as a means to those important ends,⁵⁷ and Daniels has also taken up this challenge by extending the second principle and provided a much more palatable response to be discussed in more detail later. Rawls suggests that in the original position it will be agreed these primary social goods will be distributed equally;

[T]he sensible thing is to acknowledge as the first step a principle of justice requiring an equal distribution. Indeed, this principle is so obvious given the symmetry of the parties that it would occur to everyone immediately. Thus the parties start with a principle requiring equal basic liberties for all, as well as fair equality of opportunity and equal division of income and wealth.⁵⁸

Yet as rational, intelligent beings, the intuition of those in the original position will lead to the question, what if some inequalities make everyone better off?⁵⁹ Rawls thus defends his difference principle, that inequalities in wealth are acceptable as long as the worst off are better off.⁶⁰ Yet less than equal liberty will not be allowed, because this is against the intuition of basic justice and one of the key arguments against utilitarianism and so the principles are lexically ordered, giving priority to liberty and meaning liberty can only be restricted for the sake of liberty. A line will be drawn, and allowing less than equal liberty for the sake of any other good will not be accepted, thus explaining the lexical ordering of the two principles.⁶¹

⁵⁶ Rawls J, 'Social unity and primary goods' (n 53).

⁵⁷ Barry B (n 12) 31.

⁵⁸ Rawls J, *A Theory of Justice* (n 12) 130.

⁵⁹ *ibid* 131.

⁶⁰ Barber B, 'Justifying Justice: Problems of Psychology, Politics and Measurement in Rawls' in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy, Stanford University Press 1989) 302-303 is critical of the difference principle designed to help those worst-off because many groups could fall into this category or have a case that they should. Rawls generally restricts it to wealth and income, which could be debatable, but is not necessary for our purposes.

⁶¹ Rawls J, *A Theory of Justice* (n 12) 131.

Rawls himself accepts that these principles may need to change and that additions will be made.⁶² As part of his appeal to intuition he suggests that we will reflect on the conditions of the original position⁶³ and if they yield obviously unjust outcomes then they may be changed. Rawls believes there are more universal principles to be added which only serves to support the basic and minimal nature of the two he does set down. Yet it is the justification for equality that is most important for establishing a right to healthcare, and the principle of equality of opportunity that the 'obvious' thoughts of the parties would lead to. In actual fact it is the principle of *fair* equality of opportunity, which is stronger than *formal* equality of opportunity because it demands effective equal chances regardless of the natural lottery and the talents one may or may not have.⁶⁴ Fair equality therefore demands rectification of being dealt a bad hand in the natural lottery to realise equal opportunity, as opposed to formal which would merely have the principle in law but seldom in reality. This is poignant for healthcare as for those born in ill-health, every effort should be made to make them healthy and able to realise the same opportunities as those fortunate enough to be born healthy. This requirement of fair as opposed to formal equality can be used to justify the cooperation built into the Convention on the Rights of the Child.⁶⁵ The Convention envisages international cooperation to help ensure the rights of children in developing States and Rawls' theory can support this legal pragmatism.⁶⁶

4.1.3 Lifting the Veil

⁶² *ibid* 509.

⁶³ *ibid* 18.

⁶⁴ Hayden P, *John Rawls: Towards a Just World Order* (Political Philosophy Now, University of Wales Press 2002).

⁶⁵ Van Bueren G, *The International Law on the Rights of the Child* (Kluwer Law International, Martinus Nijhoff Publishers 1998) 2-3.

⁶⁶ See especially *Convention on the Rights of the Child* (1989) Article 24 (4).

After the contractors accept Rawls' principles of justice, the difficult work begins as the veil of ignorance is partially lifted and the society is challenged with crafting a constitution and legal structure, all in accordance with the basic principles. As Rawls explains; "they are to choose the most effective just constitution, the constitution that satisfies the principles of justice and is best calculated to lead to just and effective legislation."⁶⁷ Rawls proposes a four stage sequence, the first being the original position and the later three stages where the principles gradually become more elaborated in detail as specific interpretation of the law of the society takes place. The additional stages are; constitutional, legislative, and judicial. "[T]his sequence may give us a schema for sorting out the complications that must be faced. Each stage is to represent an appropriate point of view from which certain kinds of questions are considered."⁶⁸ The contractors still lack some knowledge of their own personal interests, but even if the veil is only lifted slightly, this removes any guarantees of unanimous agreement. Yet the principles of justice have been set down. The underlying principles that govern such a society have been decided and help ensure that despite all the politics that comes afterwards, the society will remain fair. The principles of justice have the paradox of being fundamentally paramount, a phrase which is a parallel juxtaposition because it places the opposites of basic and supreme together, yet it is a paradox because it is true for the principles of justice. They are *fundamental* as they are minimal, base conceptions that hold such *paramount* importance in governing and ensuring a just society, but will be largely forgotten once the constitution is written and legislation passed. They are universal minimums, but their importance cannot be underestimated. This ideal society, governed by the principles of justice as fairness, is unlike any we know. Rawls' hypothetical exercise helps us think purely about what a just and fair society would be like. "The picture that comes into focus is not

⁶⁷ Rawls J, *A Theory of Justice* (n 12) 173.

⁶⁸ *ibid* 172.

that of our blemished actual society, but rather of that society purged of its conspicuous injustices, and true to its noblest ideals.”⁶⁹

There are many things about Rawls’ substantial theory that are omitted in this discussion, and some criticisms that will be addressed below. However, whilst further discussion of Rawls is interesting, it is the ‘veil of ignorance’ and the minimal principles of justice that are important for establishing a right to healthcare. This thesis also looks at establishing a *child’s* right to healthcare, so children in a ‘Rawlsian society’ will need to be given specific focus, as well as the international law aspect of the thesis, meaning discussion will turn to laying out the part of Rawls’ philosophy that focuses on global justice in the next chapter.

4.1.4 Critics

As a form of social contract theory, Rawls’ theory of justice imagines members of a society to be contractors who have agreed to certain fundamental conditions and governing principles before entering their society.⁷⁰ Critics have argued that such an approach ignores human nature and the struggles of humanity, which any theory of justice cannot simply ignore.⁷¹ They point to its incompatibility with any human society, past or present, as evidence that it cannot fit or comply with human nature. Miller uses Marxist theory and the idea that the ruling best-off individuals have never given up any power voluntarily to argue that Rawls’ difference principle, the idea of ensuring the worst-off are as best off as possible, would not work.⁷² He assumes that the ruling class would be against the changes required by the difference

⁶⁹ Feinberg J (n 12) 1031.

⁷⁰ Rawls J, *A Theory of Justice* (n 12) 10.

⁷¹ Fisk M, 'History and Reason in Rawls' Moral Theory' in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy, Stanford University Press 1989).

⁷² Miller RW, 'Rawls and Marxism' in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy, Stanford University Press 1989) 214.

principle even if they had a sense of justice as defined by Rawls' principles.⁷³ Daniels uses similar arguments stating that Rawls' theory will produce inequalities of liberty disagreeing with Rawls' first principle. He suggests that allowing differences and inequalities in wealth will allow a best-off class to be established that historically has always had more liberty and more ability to express themselves.⁷⁴ The argument is that money equals speech, in much the same way as we have political parties requiring money for campaigning today. Rawls' response is that liberty and the worth of liberty are different; people would still be free and liberty itself remains the same, but the *worth* of liberty will be more for those who can exercise it better.⁷⁵ Both of these arguments boil down to the fact that Rawls' theory would not work perfectly in practice, even with the best of intentions, in much the same way as George Orwell's *Animal Farm* where seemingly fair and strict rules are slowly changed and broken by a ruling class that inevitably materialises.⁷⁶ However, it is important to note that such criticisms miss a major point of Rawls' theory; its concern with ideal theory.⁷⁷ Rawls is concerned with establishing a just society in which the principles of justice are followed, and nowhere does Rawls pretend or even hint that this has occurred anywhere in human history. To say that Rawls' theory does not comply with society now or any that has existed in history is to say that societies past and present have not been

⁷³ *ibid* 217.

⁷⁴ Daniels N, 'Equal Liberty and Unequal Worth of Liberty' in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy, Stanford University Press 1989) 256.

⁷⁵ *ibid* 259; Daniels does not find Rawls' response reassuring and does not believe that liberty and worth of liberty can be separated from economic inequalities as Rawls seems to try to do. Daniels himself does not establish a response or answer however, and even if liberty was connected to economic inequalities in the theory, that is not evidence of anything particularly unjust. That richer people can afford more, such as television airtime to better make their point and influence people is a corollary of accepting the difference principle to maximise the minimum.

⁷⁶ Orwell, G. *Animal Farm: A Fariy Story* (Secker and Warburg 1945).

⁷⁷ Michelman F, 'Constitutional Welfare Rights and *A Theory of Justice*' in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy, Stanford University Press 1989) 320; see also Feinberg J, 'Rawls and Intuitionism' in Daniels N (ed), *Reading Rawls* (Stanford Series in Philosophy Stanford University Press 1989) 116-117.

just: A statement which will cause scant controversy.⁷⁸ One of Miller's strongest arguments however is that if it can be shown that Rawls' theory will not work in practice, the contractors will know this lack of pragmatism and therefore will not choose the principles proposed, particularly the difference principle.⁷⁹ However this is not entirely convincing. Miller argues that we cannot remove consideration of probable outcomes from the original position,⁸⁰ but what he fails to then follow through with is that even if correct, the majority of contractors will not be, or end up, in the ruling class, so they will also consider this with the possible outcomes. This is part of Rawls' argument that the contractors would not gamble against the principles on the chance that they might be the best-off.⁸¹ Barry is not convinced contractors would not gamble.⁸² He believes that when the chance is below a certain point, we would gamble, but on Rawls' theory the contractors must not. Rawls states that the contractors would rationally choose considered conservative principles, imagining what it would be like to be in the position of the worst-off, hence the difference principle; maximising the minimum.⁸³ It would be rational for people in the original position to consider this even if they think it may be difficult in practice, in much the same way as equal liberty will be broken when someone breaks the law. The more practical implications of exercising these principles will be considered after the veil of ignorance has been lifted. Behind the veil, the knowledge is highly restricted and the economic circumstances and type of society is unknown. Rawls' difference principle is not designed to state that all decisions post original position that are even a slight gamble are irrational, but that the structure of society agreed would be

⁷⁸ MacCormick N, 'Children's Rights: a Test-Case for Theories of Right' in MacCormick N (ed), *Legal Right and Social Democracy: Essays in Legal and Political Philosophy* (Clarendon Press 1984) 155.

⁷⁹ Miller RW (n 72) 214.

⁸⁰ *ibid* 228.

⁸¹ Rawls J, *A Theory of Justice* (n 12) 144.

⁸² Barry B (n 12) 89.

⁸³ Rawls J, *A Theory of Justice* (n 12) 72-73; Rawls argues that whilst economists would call the principle of maximising the minimum a maximin principle, this is inappropriate for his difference principle because a maximin is choice under uncertainty.

to ensure the minimum is maximised via things such as welfare and opportunity (things to be further elaborated upon after the original position).⁸⁴ It makes perfect sense not to gamble on things such as liberty, welfare, opportunity and so on, because the cost of losing is so severe. If the position of the worst off is intolerable, there is a justice deficit in that society,⁸⁵ therefore we would choose a difference principle to try to ensure against this. Rawls himself considers some practical criticisms against the difference principle by acknowledging that in theory improving the position of the best off by an incredible amount would depend on increasing the position of the worst off by even the smallest amount.⁸⁶ “[I]t seems extraordinary that the justice of increasing the expectations of the better placed by a billion dollars, say, should turn on whether the prospects of the least favoured increase or decrease by a penny.”⁸⁷ Rawls’ response is that this would not really arise and become a problem, which is probably true, and certainly for a well-structured and fair society yet additionally that extra penny to the worst off is worth a lot more than an extra billion dollars to the best off, and this is the whole point of the difference principle and one its key strengths.

4.1.4.1 Feminist Critics

With a focus on children in this thesis and the subsequent discussion of children in the Rawlsian society, the critique of feminist literature on Rawls’ theory of justice should be considered. Much of the focus is obviously on women, children, and the family, and their consideration or lack thereof in the theory. There is a reason

⁸⁴ Nozick R (n 9) 204.

⁸⁵ Brassington I, *Public Health and Globalisation: Why a National Health Service Is Morally Indefensible* (Societas, Imprint Academic 2007) 33.

⁸⁶ Rawls J, *A Theory of Justice* (n 12) 136; Barry B (n 12) 108.

⁸⁷ Rawls J, *A Theory of Justice* (n 12) 136.

however why such criticisms have not gained much traction in the literature; they are based on a fundamental misconception of Rawls.

The first to consider is that by Carole Pateman, who in the *Sexual Contract*,⁸⁸ argues against the idea of a social contract as a whole because it seeks to legitimate the subordination of women. For Rawls specifically, she argues that he seeks to find an original position that will “confirm ‘our’ intuitions about existing institutions, which include patriarchal relations of subordination.”⁸⁹ A social contract seeks the conventional origin of political right, which insists men’s right over women has a natural basis.⁹⁰ As men, women, relationships and the family are not considered in Rawls’ theory, this, according to Pateman, means that it is even more likely that the state of nature as portrayed will accept and legitimate the subjugation of women. In actual fact, traditional contract theory is preferred by Pateman for at least considering gender and relationships.⁹¹ So Pateman attacks Rawls for what is regarded as one of his biggest strengths; the thick veil of ignorance. She attacks a theory designed by its very nature to remove prejudice and the ability to subjugate anyone, by preferring to have prejudice and subjugation. The feminist is disappointed women are not given special treatment and consideration in a completely gender free society. The argument also goes that the subordination of women is part of our intuition, which, aside from being a sad state of affairs to believe, also does not consider the contractors, who may well be women themselves. This is why the subjugation of anyone, including women, would not be allowed by the principles of justice. They are guaranteed equal liberty and equal opportunity. Everyone is. Gender is not a consideration. Nor should it be. To bring gender and relationships into consideration behind the veil changes the theory and

⁸⁸ Pateman C, *The Sexual Contract* (Polity Press 1988)

⁸⁹ *ibid* 42

⁹⁰ *ibid* 41

⁹¹ *ibid* 43

its purpose drastically. This moves us neatly onto the next feminist criticism of Rawls, which is the claim that the principles of justice do not apply to the family.

Okin and Nussbaum posit a more challenging critique of Rawls in seeing the failure to subject the family to the principles of justice as a fundamental flaw of the theory.⁹² They argue that the family is not a private association as Rawls suggests but in actual fact; “The state constitutes the family structure through its laws, defining which groups of people can count as families”.⁹³ Thus the family is, to a large extent, a State creation and therefore the principles should apply. Nussbaum’s argument that the family is to a large extent the creation of the State is surely contentious as societies idea of family is not always the same as the law, and indeed both have changed even over the last few years, for instance with gay marriage and the law responding to societies changing views. Okin argues a similar point that it is the *structure* of the family that should be subject to the principles of justice or else the gendered family structure that will result will not be just and will promulgate the ancient subjugation of women.

[A]lthough one has some choice (albeit a highly constrained one) about marrying into a gender-structured family, one has no choice at all about being born into one. Rawls’s failure to subject the structure of the family to his principles of justice is particularly serious in light of his belief that a theory of justice must take account of “how [individuals] get to be what they are” and “cannot take their final aims and interests, their attitudes to themselves and their life, as given.”⁹⁴

⁹² Okin S, *Justice, Gender and the Family* (Perseus Books 1989); Nussbaum M, ‘The Future of Feminist Liberalism’ (2000) 74 *Proceedings and Addresses of the American Philosophical Association*

⁹³ Nussbaum M, ‘The Future of Feminist Liberalism’ (n 92) 60

⁹⁴ Okin S (n 92) 97

Rawls responds directly to this criticism by failing to see the problem within the scope of his theory. The objection that the principles do not apply to the family is one Rawls has no problem with because it is not what his theory is trying to achieve, yet the objection that this lack of application will mean unequal justice for women and children is also one Rawls rejects. In a direct response to Okin, Rawls states;

This is a misconception. It may arise as follows: the primary subject of justice is the basic structure of society understood as the arrangement of society's main institutions into a unified system of social cooperation over time. The principles of political justice are to apply directly to this structure, but they are not to apply directly to the internal life of the many associations within it, the family among them.⁹⁵

The principles are not and never were designed to be applied to the family structure. If they were to be applied, as is called for, Rawls hardly sees this as desirable, as it would require raising children in accordance with political principles determined by society. Whilst there should be some conception of justice, at some point the natural affection of parents must be trusted by society, so feminists should be wary of treating the family structure and children as State institutions to be governed by the principles of justice.⁹⁶

4.1.4.2 Habermas and Rawls

Jürgen Habermas has also commented extensively on Rawls' work in light of his own theory geared towards ideal discourse. The focus for the criticism of Habermas is on the constraints Rawls' places on his theory, particularly on the original position and the two principles thereafter. For Habermas, these principles are not necessary,

⁹⁵ Rawls J, (edited by Kelly E). *Justice as Fairness* (n 2) 164

⁹⁶ *ibid* 165

and the entire theory, by its constrained nature, is dependent on Rawls' own substantive normative assumptions as a US citizen.⁹⁷ Habermas' theory is one of so-called ideal discourse which Rawls suggests is based on another difference between them; Habermas is concerned with a comprehensive doctrine, whereas Rawls has limited himself to the political.⁹⁸ From this difference, Habermas takes up ideal discourse as opposed to Rawls who uses the original position.

For Habermas, the principles of justice are unnecessary because such constraints to ensure just and reasonable outcomes will occur naturally in democratic discourse. Post original position, for Rawls, the two principles constrain majority rule to ensure a just outcome. For Habermas, this substantive constraint is unnecessary as there is no criteria for what constitutes the right answer before argumentation, yet there are guiding values for ideal discourse.⁹⁹ These values are to ensure that discourse is ideal which in turn will then lead to natural constraints to ensure just outcomes without the need for substantive pre-approved constraints. However Rawls argues that these values are by their nature the substantive constraints Habermas seeks to avoid. These values are included in the procedure of discourse to ensure outcomes are just and reasonable, so by their nature they are substantive principles.¹⁰⁰

Secondly Habermas has also mentioned that the entire theory is constrained by Rawls own view as the theorist and designer, necessarily predicting the

⁹⁷ Habermas J, 'Reconciliation Through the Public use of Reason: Remarks on John Rawls's Political Liberalism' (1995) 92 The Journal of Philosophy 109; Habermas J, 'Life-Forms, Morality and the Task of the Philosopher' in Dews P (ed), *Autonomy and Solidarity: Interviews with Jürgen Habermas* (Verso 1992) 200-201; Gledhill J, 'Procedure in substance and substance in procedure: reframing the Rawls-Habermas debate' in Finlayson JG, and Freyenhagen F. (ed), *Habermas and Rawls: disputing the political* (Routledge studies in contemporary philosophy, Routledge 2011) 182.

⁹⁸ Rawls J, 'Political Liberalism: Reply to Habermas' (1995) 92 The Journal of Philosophy 132, 138.

⁹⁹ *ibid* 173. There are five guiding values; impartiality, equality, openness, lack of coercion and unanimity.

¹⁰⁰ *ibid* 173.

assumptions to be made.¹⁰¹ However this is the very reason Rawls uses pure procedural justice at the highest level of his theory in the original position.¹⁰² The just outcome is unknown, but the procedures are fair so the outcome will be also. Rawls only allows reasonable doctrines within the original position because unreasonable doctrines will be banished by the conditions imposed by the veil of ignorance. This will therefore lead to an overlapping consensus that justifies the theory as universal and not merely the conceptions and views of John Rawls with his prejudice.

4.2.4.3 Nozick and Pogge

Any discussion and justification of using Rawls cannot be complete without analysis of Robert Nozick's "most important and thought-provoking"¹⁰³ response to Rawls in *Anarchy, State, and Utopia*.¹⁰⁴ For a long time this response seemed to defeat the importance of Rawls' theory, until Thomas Pogge highlighted the key and fundamental misunderstandings of Rawls work that Nozick presents to offer his critique.¹⁰⁵ One of Nozick's main concerns is that Rawls does not consider historical entitlement theories and Nozick believes, because of the difference principle and lack of moral entitlement, Rawls' theory will require some unwarranted and unacceptable intrusion into a person's holdings by an organisation or established authority.¹⁰⁶ Nozick personally believes such measures are inappropriate because

¹⁰¹ Habermas J, 'Reconciliation Through the Public use of Reason (n 97) 118.

¹⁰² Gledhill J (n 97) 191.

¹⁰³ Bix B, *Jurisprudence: Theory and Context* (Fourth edn, Sweet & Maxwell 2006) 111.

¹⁰⁴ Nozick R (n 9).

¹⁰⁵ Pogge T (n 27).

¹⁰⁶ Nozick R (n 9) 199, 203-204, 207 and 215; Nozick's concern with historical entitlement comes from his view of justice in distribution. Unlike Rawls Nozick believes the importance of determining distributive justice is *how* the distribution came about and as long as it was voluntary, there are no justice concerns.

distribution of property and other patterned principles¹⁰⁷ and holdings should be based on moral merit determined by such things as usefulness to society and intelligence. Nozick therefore believes the intrusive measures Rawls' theory requires are inappropriate and disagrees that any differences in holdings that arise due to differences in natural assets means a later redistribution should occur as the difference principle requires.¹⁰⁸ However, as Pogge points out; "Nozick expends much effort attacking a view that is not Rawls's."¹⁰⁹ Nozick attacks many positions of Rawls' using examples that would be post original position and he fails to distinguish between how the ground rules (the principles of justice) of a society ought to be designed, and individual actions and how people or organisations should act within such a society whose terms are fixed.¹¹⁰ Nozick focuses a lot on the cooperation of the best off and the worst off and how the difference principle would appeal to them or not.¹¹¹ However, this argument is post veil as in the original position the contractors would have no idea whether they would be best off or worst off. Nozick even accepts this,¹¹² but then mistakenly considers that the individuals behind the veil might consider the possibility of being in the best off situation and criticises Rawls for not having such a discussion of cooperation between the best and worst off individuals behind the veil. This again mistakes the very point of Rawls' theory, as such a discussion could not occur between the individuals who do not know to which category they belong and considering themselves to be in the best off situation is something Rawls does not accept.¹¹³ The contractors would not gamble on that possibility, and would design the principles imagining themselves to

¹⁰⁷ Patterned principles are those where distributive justice is considered based on the pattern of distribution at a given time. This is a major difference between Rawls and Nozick. Rawls has patterned principles; Nozick has historical entitlements.

¹⁰⁸ Nozick R (n 9) 226.

¹⁰⁹ Pogge T (n 27) 17.

¹¹⁰ *ibid* 17.

¹¹¹ Nozick R (n 9) 189-198.

¹¹² *ibid* 196-197.

¹¹³ Rawls J, *A Theory of Justice* (n 12) 144.

be in the worst off position therefore ensuring this would be tolerable. This is the very idea of the difference principle; designing a principle they would all accept, even if they were in the worst off position and not looking at it through the eyes of possibly being one of the best off.

One of Nozick's key misunderstandings of Rawls is his concern that the theory purports some intrusive redistribution that Nozick would find an anathema.¹¹⁴ Nozick thinks that some authority (the government) will come to your house and take any spare money to support a large scale redistribution of wealth it is carrying out. Pogge rightly argues that that is not what Rawls' theory would accept or encourage at all.¹¹⁵ The purpose is that the institutions that control economic distribution of resources should be changed, and be different to what they are now, *in the first place*.¹¹⁶ In much the same way as tax is taken out of a pay cheque before you see it or have the chance to spend it, the idea is that the redistribution that Nozick fears would never occur because it has already happened. This economic misunderstanding continues when Nozick criticises the patterned principles of Rawls' theory which Nozick thinks will predetermine who gets what, and that such a predetermined distribution will be vulnerable to corruption by independent choices of individuals.¹¹⁷ Nozick favours unpatterned principles which would set out procedures through which one can acquire holdings, and then leave it alone.¹¹⁸ Nozick again mistakes Rawls and actuarially fails to see some similarities in their work. It is true that the difference principle involves the patterned principle idea that some economic distributions are better than others. But much like Nozick's unpatterned idea, the difference principle is laying out the ground rules as the most just system,

¹¹⁴ Nozick R (n 9) 149-153.

¹¹⁵ Pogge T (n 27) 17 and 27.

¹¹⁶ *ibid* 27.

¹¹⁷ Nozick R (n 9) 160-164.

¹¹⁸ *ibid* 155-160.

and then, if followed and it is in fact the most just system, Rawls would also leave distribution alone as there would be no need to interfere.¹¹⁹

Nozick believes that Rawls' position encourages an infringement of what he believes are fundamental rights, such as property,¹²⁰ but again it is argued from a position post veil of ignorance. Rawls' theory would not support infringement of such fundamental property rights, but would hold from a higher level that such rights are not so fundamental and therefore should not exist in the first place.¹²¹ However for Nozick, any first acquisition of land, grabbed in a fair way using any talents, is just and so one individual could hold 100% of land which for Nozick would be a just holding. That individual alone can coercively decide what subsequent acquisitions may take place.¹²² Nozick argues this would be micro acquisition, between individuals, and that it would be infringed by the macro acquisition Rawls' institutions would adopt.¹²³ For Nozick, it would be unacceptable for principles to exclude such micro acquisitions from consideration as he argues Rawls' theory does.¹²⁴ However, the individual transfer is not a small scale issue so as to make it micro as opposed to the large scale conduct between institutions which would be macro.¹²⁵ Both of them raise questions about the conduct within institutions instead of about institutions, which is what Rawls is concerned with. "Rawls focuses on the fundamental "rules of the game" and not on what moves players are morally free or constrained to make within a particular game in progress."¹²⁶ This is once again the same key to Nozick's fundamental misunderstanding of Rawls. Nozick criticises

¹¹⁹ Pogge T (n 27); Rawls J, *A Theory of Justice* (n 12) 76-77.

¹²⁰ Bix B (n 103) 112; Pogge T (n 27) 37.

¹²¹ Pogge T (n 27) 37.

¹²² This itself is a main criticism of Nozick's own theory because it would lead to unfair bargaining and possible slavery, which is also one of the main justifications for not using Nozick's even more minimal theory. Yet this is something Nozick has no issue with because he believes any free society should allow someone to sell themselves into slavery, no matter how much coercion there may, and will likely, be. See Nozick R (n 9) 331.

¹²³ *ibid* 204-206.

¹²⁴ *ibid* 206.

¹²⁵ Pogge T (n 27) 25.

¹²⁶ *ibid* 27.

Rawls for what may happen after the veil. What he thinks may happen is mistaken and it is also not Rawls' focus.

It is hoped that some major critics of John Rawls' theory have been successfully addressed in so that *A Theory of Justice* will serve as a solid grounding for further discussion of a child's right to healthcare and the State's obligation to provide it. The following discussion of potentially placing children in the original position and the rational nature of the contractors will show that the principles of justice will be applied equally to children after it is shown that the principles do indeed provide for a fundamental right to healthcare.

4.2 Interpreting the principles

To reiterate, behind a 'veil of ignorance' and in a hypothetical original position in which we have no knowledge of who we are as individuals, John Rawls argues we would decide on two minimal principles of justice with which to govern our society once the veil is lifted. These principles are;

- (a) Each person has the same inalienable claim to a fully adequate scheme of equal basic liberties, which scheme is compatible with the same scheme of liberties for all; and
- (b) Social and economic inequalities are to satisfy two conditions: first, they are to be attached to offices and positions open to all under conditions of fair equality of opportunity; and second, they are to be to the greatest benefit of the least-advantaged members of society (the difference principle).¹²⁷

These principles are the base, underlying conditions for society. Once the veil is lifted and society forms having gained knowledge of themselves and their

¹²⁷ Rawls J, (edited by Kelly E) *Justice as Fairness* (n 2) 42-43.

generation, the people will come together to create a constitution and set up institutions in accordance with these principles. In time the principles will cease to be used, yet the society will still be a just one as all the institutions, legislation and the constitution will have been formed and created in accordance with these principles. This is all hypothetical of course.

It is argued here, as have others before,¹²⁸ that a right to healthcare will arise from Rawls' minimal principles of justice, thus providing a strong argument for a moral obligation of the State to ensure healthcare to all, especially children. Leary suggests that justice is one of the fundamental principles of human rights, and the concept of a right to health makes justice a relevant issue to healthcare.¹²⁹ This connection of health being a matter of justice is a major theme of this chapter and why a strong theory of justice such as Rawls is used. In particular, it is the second principle of justice, *fair equality of opportunity*, which is suggested to lead to this right.

4.2.1 Equal Opportunity, Equal Healthcare

Norman Daniels first made the connection between Rawls' second principle and healthcare in 1985 in his book *Just Health Care*. His later work, *Just Health* (2008) follows the same discussion of Rawls but focuses, as the name suggests, on health as opposed to healthcare. Daniels explains this change as attributable to being persuaded as to the importance of public health in ensuring the health of a population, and that healthcare is just one aspect of this. Whilst this is true, for the purposes of this work and the focus on healthcare systems as seen in chapter one,

¹²⁸ Daniels N, *Just Health* (n 1); see also Leary VA, 'The Right to Health in International Human Rights Law' (1994) 1 *Health and Human Rights* 25, 27.

¹²⁹ Leary VA (n 128) 27.

as well as the legal arguments around the right to health, the focus will be on healthcare provision by the State.

Daniels' extension from Rawls' principle of equality of opportunity is actually fairly simple and follows arguments Rawls uses for education. Throughout a theory of justice Rawls mentions the importance of public education for the principle of fair equality of opportunity.¹³⁰

I assume also that there is fair (as opposed to formal) equality of opportunity.¹³¹ Proportional expenditure (or income) taxes are to provide revenue for public goods, the transfer branch and the establishment of fair equality of opportunity in education, and the like, so as to carry out the second principle.¹³²

The first point Daniels makes to encompass healthcare, is to compare health needs and educational needs.¹³³ Both are not equally distributed and various factors (social and natural) may produce special needs for each. Both are also vital contributors to the principle of fair equality of opportunity. Thus Daniels argues that "Rawls's argument about the importance of public education for fair equality of opportunity is readily broadened to include health care. Any justification for the one extends to the other."¹³⁴ The simplicity of Daniels' argument is clear from his summary:

(1') Since meeting health needs promotes health (or normal functioning), and since health helps to protect opportunity, then meeting health needs protects opportunity. (2') Since Rawls's justice as fairness requires protecting opportunity, as do other important approaches to distributive justice, then several recent accounts of justice give special importance to meeting health needs.¹³⁵

¹³⁰ Rawls J, *A Theory of Justice* (n 12) 63, 86-7, 243-7 and 265.

¹³¹ *ibid* 243.

¹³² *ibid* 247.

¹³³ Daniels N, *Just Health* (n 1) 60-1.

¹³⁴ *ibid* 61.

¹³⁵ *ibid* 30.

Daniels argument is that protecting health needs protects opportunity and since there is an obligation to protect opportunity, there is an obligation to protect health needs. Part of protecting health needs is by ensuring healthcare, which, much like public education, requires a public and universal system if it is to be provided to everyone as justice requires. In other words: a theory of justice requires the provision of healthcare, because of the opportunities being healthy provides. No one should be disadvantaged in life because of factors that are beyond their control, and it is fundamentally unfair for someone's life to go better because they have been provided with substantially more opportunities and resources.¹³⁶ Archard agrees that with this argument and in particular with childhood which has even greater importance¹³⁷ with children having more need of opportunities.

One vitally important aspect of Daniels' extension is that Rawls himself accepted the argument some years after Daniels first proposed the idea, writing in 2001 that:

[P]rovision for medical care . . . falls under the general means necessary to underwrite fair equality of opportunity and our capacity to take advantage of our basic rights and liberties, and thus to be normal and fully cooperating members of society over a complete life.¹³⁸

Given that "ordinary mortals can be reasonably confident that they will, at some point, find themselves capable of benefiting from some kind of health intervention, and that providing for such an eventuality would be wise",¹³⁹ protecting everyone's opportunities requires ensuring everyone has access to medical care. Interestingly, the UN Committee on Economic, Social and Cultural Rights has also made this connection between health and opportunity in General Comment 14. In paragraph 8 the Committee states that the normative content of the right to health "provides

¹³⁶ Archard D (n 3).

¹³⁷ Ibid.

¹³⁸ Rawls J, (edited by Kelly E) *Justice as Fairness* (n 2) 174.

¹³⁹ Brassington I (n 85) 13.

equality of opportunity for people to enjoy the highest attainable level of health.”¹⁴⁰ Additionally the Committee has mentioned the need for judicial remedies to help ensure such rights and provide appropriate definition.¹⁴¹ This finds academic support from Michaelman who also accepts that in order to effectuate fair equality of opportunity, health care guarantees must be in place which are themselves amenable to adjudication.¹⁴² The appropriate justiciability of rights such as healthcare will be discussed in much more detail in chapter five.

Thus a powerful, convincing and minimal theory of justice, finds an obligation for the State to provide healthcare, at least at a basic level, to ensure everyone has access in order to protect equality of opportunity. The basic level of care is mentioned for two reasons. Firstly it acknowledges that other services protect opportunity, such as education as discussed, and so provision of healthcare cannot be the only way the State ensures protection of opportunity. Secondly, ensuring at least a basic level of healthcare accepts that a State is restricted by resources. This basic level requirement also connects neatly with later discussion on the human right to healthcare and enforcement of the right which has to start with fulfilling the ‘minimum core’. Until this fulfilment is achieved, there is little point in striving for more in States that cannot afford it, or the obstinate ones that actively refuse their obligations.

¹⁴⁰ Committee on Economic, Social and Cultural Rights. General Comment No. 14 - the Right to the Highest Attainable Standard of Health, 2000. Vol. UN doc.E/C.12/2000/4 (hereafter General Comment 14) paragraph 8 – the Committee are stating that the right to health is not a right to be healthy, but to have the same opportunity to be healthy as everyone else. It is still a clear connection between opportunity and health.

¹⁴¹ Committee on Economic, Social and Cultural Rights. The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights. 1987 UN Document E/CN.4/1987/17 (hereafter The Limburg Principles) 19; General Comment 14, 9.

¹⁴² Michelman F (n 77) 344.

4.2.2 Objections

One criticism of the second principle comes from Barry who focuses on the economic inequalities in a similar way to Rawls.¹⁴³ Barry's main focus is on the difference principle and the redistribution of wealth it requires, which is important for discussion on global economic redistribution in chapter 6. Barry's main objection is that fair and equal distribution is not as straightforward as supposed by Rawls theory.¹⁴⁴ Michaelman makes similar points with Rawls focus on monetary transfer schemes and suggests that if it was really that simple then the difference principle would not allow welfare rights as such within it.¹⁴⁵ Barry's comparable argument is that redistribution of wealth is not the only element to fair distribution of social goods, or as Michaelman is searching for, welfare rights. Pogge argues that searching for the right to health through the difference principle would violate a central element of Rawls' theory as it would value life and health unequally, with their fulfilment being focused on providing the best economic and wealth outcome.¹⁴⁶ However the difference principle is not what is used in the search for healthcare within Rawls theory in this thesis.

As regards to the opportunity part of the second principle Barry accepts that this raises barely any difficulties.¹⁴⁷ He accepts the principle aims to achieve a meritocracy and uses Michael Young's definition of IQ + effort.¹⁴⁸ This shows that nature cannot be fully controlled for, but there are other elements to a fair and just meritocracy. One of these elements is effort, yet in order to be able to put in the effort, the opportunity to do so is needed. Whilst Barry accepts the opportunity part

¹⁴³ Barry B (n 12) 43.

¹⁴⁴ Barry B (n 12) 43-49.

¹⁴⁵ Michelman F (n 77) 323.

¹⁴⁶ Pogge T (n 27) 181-2.

¹⁴⁷ *ibid* 51.

¹⁴⁸ Young M, *The Rise Of The Meritocracy* (Thames and Hudson 1958).

of the second principle, he does not look for health care provision within it. Instead he argues that healthcare would be assured in the original position because of the conservative nature of contractors not gambling and wanting to protect themselves against being one of the severely ill in a world where they cannot afford healthcare.¹⁴⁹ This is a possible extension with the contractors obviously considering various possibilities, such as the presence of children and applying the principles to them. Michaelman however, in his search for welfare rights, highlights that Rawls cannot and does not want basic needs such as healthcare to be the approach of his theory because this would necessarily require an objective approach towards them.¹⁵⁰ Rawls does not want such specificity and objectiveness in the original position but instead accepts delaying that until the later constitutional phases. The aim for Rawls is to keep the original position as minimal and as uncontroversial as possible with complete overlapping consensus. This assures the principles' universality, and then if a necessary extension of those fundamentally paramount principles is free healthcare in order to abide by justice as fairness, it provides a stronger argument that even a minimal theory of what it takes to be a just and fair society requires equal provision of healthcare services.

One of the main and surprising critics of Daniels' extension is Pogge. His discussion and mistaken criticism of Daniels' approach is however plagued with confusion on his own thoughts as he proposes his own ideas. Pogge believes Daniels position has serious problems because Daniels allows inequality in healthcare, to those who need it the most, but not education.¹⁵¹ This is a complete misunderstanding of Daniels' position, which is not a priority of health and healthcare over education, but simply an argument that health and healthcare in a way similar to education strongly

¹⁴⁹ Barry B (n 12) 56-57.

¹⁵⁰ Michelman F (n 77) 331.

¹⁵¹ Pogge T (n 27) 184.

influence equal opportunity and is therefore a matter of justice.¹⁵² There will be some people who require more education and special attention in school for example in order to realise equal opportunities to other compatriots more naturally talented, in the same way that some will require more medical care than others because of life-long chronic conditions. Daniels is merely arguing that it is a matter of fundamental justice that those who are not naturally as talented or as healthy are given the same opportunities, which requires access to quality healthcare.

Pogge suggests that his arguments are quite different from Daniels, however it can be argued that both ideas are actually very similar. Pogge surprisingly states: “As far as justice is concerned, medical need as such does not the support a valid claim to medical care. It is not an injustice, even in a very affluent society, if little is spent on health care (or education).”¹⁵³ Pogge also criticises a difference between education and healthcare in Daniels’ work that does not exist, and then contends that we conceive of health as a social good in the same way as education and employment, but calling it health protection, meaning that we have access to medical care when needed.¹⁵⁴ Allocations to the medical systems should be decided by the political process as a matter of pure procedural justice. Pogge here is showing a surprising confidence in the political process and that no matter what resource allocation decisions are made, they will be fair as long as done via pure procedural justice. In themselves, the social goods funded by such decisions do not raise questions of justice. This is where Daniels’ extension of the second principle is

¹⁵² To be fair to Pogge, Daniels had only written ‘Just Health Care’ at the time he criticised him in ‘Realizing Rawls’. In his later work Daniels renamed it to ‘Just Health’ and explained that the reason was because he had been persuaded by arguments that there are many different aspects to realising health and health care is just one of those. In this way there is more made of health generally and not only healthcare, and therefore it is easier to see Daniels’ idea that healthcare is a part of realising health which is a part of realising equal opportunity, but not ‘the’ way to realise it.

¹⁵³ Pogge T (n 27) 184.

¹⁵⁴ *ibid* 185.

superior as it creates healthcare, at least at a basic level, as a matter of a just society.

Thus when Pogge proposes health protection *instead* similarly to education and employment as something we will get when needed, and, that given the difference in natural constitutions something which will not be provided completely equally to everyone,¹⁵⁵ it is based on a misunderstanding that Daniels believes that providing needed healthcare no matter the costs is the only way to fulfil Rawls' second principle. Pogge suggests that the equal opportunity principle requires only minimally adequate healthcare for natural conditions and full protection for any health conditions that are socially produced.¹⁵⁶ He proposes that the opportunity principle requires formal equality of medical opportunity as well as education and employment opportunities¹⁵⁷ and that the barometer of what is acceptable is not equal opportunity in itself but how far opportunities fall below the middle range.¹⁵⁸ The crucial problem that arises from such a view is that Pogge sees no problem with very little being spent on healthcare. The middle range can be very low because nothing is spent on healthcare or education. Daniels finds the obligation to ensure at least basic health care services to ensure protection of opportunity as we must constantly help those who have limited opportunities.

Whilst Daniels invokes Rawls most and discusses *A Theory of Justice* more extensively, he also argues that other prominent theorists support the importance in healthcare and that unlike Pogge see a minimum standard as a matter of justice. Perhaps the most important and influential alternative to Rawls is the capabilities approach developed by Martha Nussbaum and Amartya Sen. This is a different approach to Rawls, who does not want basic needs to be part of the theory as this

¹⁵⁵ *ibid* 185.

¹⁵⁶ *ibid* 193.

¹⁵⁷ *ibid* 195.

¹⁵⁸ *ibid* 197.

would go beyond the minimal nature and require a much more objective and specific approach. The capabilities approach however goes further and requires much more as a matter of justice. This alternative theory will be briefly discussed below to show that healthcare will be found within this as well, but also to show how specific and all-encompassing this theory is which explains the dominance of Rawls in this thesis as a minimal theory which therefore is more likely to see universal agreement. In the following section the position of children within Rawls' theory will be clarified to show it is perfectly acceptable to use such a strong, minimal theory of justice to defend children's rights, and that use of much more specific, elaborate and therefore objectionable theories like the capabilities approach, are not as necessary as many seem to suggest.

4.3 Application to Children

An attempt to incorporate children into the Rawlsian society outlined above will now be undertaken. It has been suggested that traditional social contract theories struggle with entitlements for children.¹⁵⁹ Rawls however, does not propose a *traditional* social contract theory.¹⁶⁰ To begin with, the position of children within Rawls' theory will be established by acknowledging that although children are not contractors themselves, it can be shown that they are considered in the original position. Given this consideration, it is argued that the two principles of justice will

¹⁵⁹ Dixon R, and Nussbaum MC, 'Children's Rights and a Capabilities Approach: The Question of Special Priority' (2012) 97 Cornell Law Review 549.

¹⁶⁰ McBride WL (n 16) 993.

apply to children once the veil is lifted. It is necessary for some extensive discussion on the absence of children in the original position as there is limited literature written on the topic and much of what there is seems largely mistaken. Bestowing the principles on children will lead to a conclusion that children will possess the various rights that stem from them.

4.3.1 Children in the Original Position

So what is the position of children within such a theory? Rawls does not deal extensively with the position and rights of children,¹⁶¹ although I think what he does do is enough, and we can also search for the answer by looking at the persons in the original position. As mentioned, the contractors in the original position are rational beings and Rawls explicitly states that children do not possess the ability to “rationally advance their interests”.¹⁶² Therefore it seems that as children are not rational beings according to Rawls they would not be contractors in the original position. However, there is some inconsistency within Rawls’ theory when he suggests that the parties in the original position would not know to which generation they belong.¹⁶³ Some authors mistakenly believe that this means it is possible for the contractors to find themselves as children once the veil is lifted, and it is this possibility that would make them protect children with the principles of justice.¹⁶⁴ But given the requirement of rationality, and the irrationality of children, the contractors would be able to deduce that they are not young children at the very least. Shaw agrees with this yet believes it is a flawed ‘peeping’ through the veil. Yet this in no

¹⁶¹ MacDougall DR (n 51) 134.

¹⁶² Rawls J, *A Theory of Justice* (n 12) 218.

¹⁶³ *ibid* 118.

¹⁶⁴ MacDougall DR (n 51) 131, 134 and 141; see also DiSilvestro R, ‘Human Embryos in the Original Position?’ (2005) 30 *Journal of Medicine and Philosophy* 285.

way changes the principles and so is not something to concern ourselves with.¹⁶⁵ DiSilvestro mistakes much of Rawls' arguments when he contends that the fact that moral persons are capable of having a conception of the good and a sense of justice, shows the capacities those in the original position have, even if they are not fully realised yet.¹⁶⁶ DiSilvestro thinks this means contractors could become children and so they would protect against this possibility. Yet as will be shown in the next section in more detail, Rawls is simply bestowing the principles of justice on children because they have the capabilities to become rational beings with a conception of the good and a sense of justice. In a catastrophic misunderstanding of the veil of ignorance, DiSilvestro spends a lot of time arguing that the contractors would protect against the possibility that they will become incapacitated once the veil is lifted¹⁶⁷ – ignoring the possibility that such individuals themselves would be irrational and therefore not in the original position. The people in the original position are the same as they are when they are out of the original position and the veil of ignorance is lifted. It is a hypothetical exercise all rational adults can try themselves; this is why it is called a veil of ignorance. Considering what a veil is designed for, it shows that the talents and interest and so on are hidden from the contractors. They have them, but they do not *know* they have them. Contractors are *ignorant* of their talents and interests because they are hidden from them behind a *veil*. It must be assumed then that the parties in the original position are rational adults, and potentially rational adolescents, but not irrational children. It cannot be the case that in the original position only rational beings are present, yet find themselves as irrational one year olds, for example, once the veil is lifted.

¹⁶⁵ Shaw DM, 'Justice and the Fetus: Rawls, Children, and Abortion' (2011) 20 Cambridge Quarterly of Healthcare Ethics 93, 99.

¹⁶⁶ DiSilvestro R (n 164) 293-294.

¹⁶⁷ *ibid.*

4.3.2 Applying the Principles to Children

In a very short article which appears to be one of the few that refers to Rawls and children in a similar way to that used here,¹⁶⁸ Evers states that since the parties in the original position “know they are contemporaries and they know they are not irrational children, they know they are adults and hence know of their common status as adults in the society after they leave the original position.”¹⁶⁹ Evers’ key idea is that children and the descendants of the adult contractors “may not accept these ancestors as spokesmen”,¹⁷⁰ which would thus weaken the intergenerational elements of Rawls’ principles. Yet I suggest that Evers misses a key point of Rawls’ theory: the hypothetical nature allowing any rational being to undertake the exercise at any point and go behind the ‘veil of ignorance’.

That the contractors know they are necessarily rational beings changes nothing. Whilst I agree with Evers that only adults, or certainly rational beings - which excludes many children, are present in the original position, he stretches his argument too far when suggesting that this means Rawls is wrong to say that “no one knows his situation in society, . . . and therefore no one is in a position to tailor principles to his advantage”.¹⁷¹ Here, Evers is suggesting that the rational beings in the original position will be able to modify the principles of justice to their advantage because they have knowledge of who they are, because they know they are rational beings, and therefore most probably an adult. However, this is not as straightforward as Evers suggests. Knowing yourself and other contractors are adults would not be enough to tailor the principles. This knowledge is the same, according to Rawls’ ideas, as knowing that you, and others around you, are rational.

¹⁶⁸ Others include, Shaw DM (n 165); MacDougall DR (n 51) who focus on slightly different issues such as what extending the principles to children would mean for abortion.

¹⁶⁹ Evers WM, 'Rawls and Children' (1978) 2 *Journal of Libertarian Studies* 109, 109.

¹⁷⁰ *ibid* 110.

¹⁷¹ Rawls J, *A Theory of Justice* (n 12) 120-121; Evers WM (n 169) 110.

No other knowledge about yourself is gained. There are still endless possibilities as to who you may be once the veil is lifted. You may be a young adult, or old. You may be a man or a woman. You may be black or white, smart or stupid, talented or lacking in many basic skills. Nothing is known about yourself except that you are rational and merely knowing you are rational, and probably an adult, cannot be nearly enough to manipulate the principles in your favour as Evers suggests. As mentioned earlier, Shaw makes the same suggestion as Evers, however, whilst it is unclear whether Shaw believes the principles will be manipulated, he states that it will not affect children because despite knowing we cannot be children, we would still choose principles that would protect them.¹⁷²

The prospect of the contractors' descendants having to abide by the principles and therefore not accepting them or their ancestors as spokesmen for themselves is also an idea I find fault with. These descendants can go into the hypothetical original position themselves and will decide on the same principles. This is similar for children as they will gain rationality and eventually be able to undertake such an exercise to decide on the two principles as well. Obeying the principles in the meantime is similar to how children are expected to obey laws they have no say in, but may well understand and appreciate when they grow up.¹⁷³ Adults accepting the principles bestowed upon them when they were children, involves a form of future-oriented consent.¹⁷⁴ the idea that the children will come to understand and accept the principles when they themselves are adults. In this way children are passive beneficiaries and have had their interests protected, as discussed in 2.1.1.

¹⁷² Shaw DM (n 165) 99.

¹⁷³ Of course the laws are made at a point of contention and political disagreement so many may grow up and still disagree, but this is not a concern for the minimalist universal principles of justice.

¹⁷⁴ Dworkin G, 'Paternalism' (1972) 56 The Monist 64.

The main argument in favour of bestowing the principles on children and affording them the same protection, is the concept of intergenerational justice which is pivotal to incorporating children into a Rawlsian society as it shows that even in the original position, children will be considered. Rawls suggests that the adults are representing family lines and therefore will be concerned with the welfare of subsequent generations:

[W]e can assume that they are heads of families and therefore have a desire to further the well-being of at least their more immediate descendants. . . . I believe that the whole chain of generations can be tied together and principles agreed to that suitably take into account the interests of each (§§24, 44). If this is right, we will have succeeded in deriving duties to other generations from reasonable conditions.¹⁷⁵

Thus the contracting parties are aware of generations before and after themselves and as such are concerned with them. This fits neatly with the hypothetical nature of Rawls' original position in which the parties are not sure to which generation or society they belong; it could be the very first, last, or one in between, but this makes no difference to the principles of justice that will be decided. Each generation and society will imagine the *possibility* of those before and after, whilst also deciding principles for itself with no knowledge of the society they will enter into.¹⁷⁶

It is clear then that rational beings are alone present in the original position, which means predominantly adults, however they think clearly about subsequent generations and children, by "imagining themselves to be fathers . . . they . . . ascertain how much they should set aside for their sons and grandsons by noting what they would believe themselves entitled to claim of their fathers and grandfathers."¹⁷⁷

¹⁷⁵ Rawls J, *A Theory of Justice* (n 12) 111.

¹⁷⁶ *ibid* 252; Intergenerational justice applies the difference principle to future generations, requiring a suitable amount of capital accumulation to be put aside in a just savings principle.

¹⁷⁷ Rawls J, *A Theory of Justice* (n 12) 256.

Rawls here is talking of the 'just savings' principle, an omission from the above discussion. It is enough for our purposes that the principle focuses on explaining the suitable amount of real capital accumulation and savings required by justice between generations in order to help establish and preserve the basic structure over time.¹⁷⁸ The important point is that children are thought of by the parties in the original position,¹⁷⁹ even if they are not present themselves. Rawls' later changes the motivation for this consideration in answer to difficulties raised,¹⁸⁰ yet subsequent generations are still considered and legitimate expectations made of them. Different generations being in the original position justifies the just savings principle, and imagining subsequent generations is a natural corollary of that. It is also clear that children are thought of in a favourable way, and that the rational beings in the original position do not have enough knowledge, by knowing they are probably adults, to tailor the principles in their favour.

4.3.3 Extension through Freeman and Dworkin

There is another option which supports finding the principles bestowed on children in Michael Freeman's work on Rawls, although he focuses much more on respecting the autonomy of children that prove themselves rational.¹⁸¹ Freeman leans on Dworkin's invocation of Rawls and then extends it to include children in an

¹⁷⁸ For much in depth discussion see Rawls J, *A Theory of Justice* (n 12) 251-258; Rawls J (edited by Kelly E), *Justice as Fairness* (n 2) 159-161.

¹⁷⁹ Shaw DM (n 165) 96.

¹⁸⁰ Rawls J (edited by Kelly E), *Justice as Fairness* (n 2) 160, Rawls states that in *A Theory of Justice* the principle assumed that contractors care about their descendants. This however raised difficulties with regards to his mutual disinterestedness in the theory and so instead it is purely seeking a correct principle that they would want and expect every generation to follow.

¹⁸¹ Freeman MDA, 'Taking Children's Rights More Seriously' (1992) 6 *International Journal of Law and the Family* 52; Freeman M, 'Taking Children's Rights More Seriously' in Freeman M (ed), *The Moral Status of Children: Essays on the Rights of the Child* (Martinus Nijhoff Publishers 1997).

interesting way. I will return to Freeman's arguments shortly, but first I turn to Dworkin.

Dworkin himself likes Rawls' idea of the 'veil of ignorance' being used to form the principles and structure of society, but believes the actual contract argument is more of a halfway point in a "deeper political theory that argues for the two principles *through* rather than *from* the contract."¹⁸² Dworkin believes the original position is an intermediate conclusion in this deeper theory because of Rawls' arguments that we should accept the original position despite its hypothetical nature as the conditions imposed by the description are ones that we would accept or can be persuaded to accept by philosophical reflection.¹⁸³ Dworkin thus searches for features of this deeper theory and finds that as Rawls' focuses on "the value of individual thought and choice"¹⁸⁴, Rawls' theory is a natural extension of a rights-based theory.¹⁸⁵ This enforces practicality on the parties as they cannot delay their decision, and distinguishes between vetoes made based only on an interest, and those made based on a fundamental right.¹⁸⁶ There will be one right on which Rawls' theory is based and Dworkin argues that because of the ignorance in the original position, that single basic right must be abstract. There are only two candidates for this right; liberty and equality,¹⁸⁷ and Dworkin argues that equality is more abstract and so the basic right from which the theory and the principles arise is the right to equal concern and respect, which Rawlsian men and women must protect,¹⁸⁸ as he explains:

The state of ignorance in the original position is so shaped that the antecedent interest of everyone must lie . . . in the same solution. The right of each man to be treated equally

¹⁸² Dworkin R (n 30) 519.

¹⁸³ *ibid* 508; see also Rawls J, *A Theory of Justice* (n 12).

¹⁸⁴ Dworkin R (n 30) 523.

¹⁸⁵ *ibid* 526-7.

¹⁸⁶ *ibid* 527.

¹⁸⁷ *ibid* 529.

¹⁸⁸ *ibid* 527 – 532.

without regard to his person or character or tastes is enforced by the fact that no one else can secure a better position by virtue of being different in any such respect.¹⁸⁹

The original position then, according to Dworkin, is a device for testing the competing arguments, and a tool for enforcing, this abstract right which is the “fundamental concept of Rawls’s deep theory.”¹⁹⁰ This right is not a product of the contract, but rather a condition of entry to the original position as it follows from possession of the moral personality of those who can give justice. Those who can give justice are the only people allowed to contract – rational adults with an innate sense of justice and possessing this moral personality.¹⁹¹ Dworkin thus supports a right to equal concern and respect as the morally fundamental idea for Rawls’ theory, however Freeman argues Dworkin does not take us far enough. Freeman extends Dworkin’s work in two ways. First, Freeman generalises Dworkin’s right of equal concern and respect for *all* citizens, and argues that this includes children.¹⁹² Secondly, Freeman argues equality by itself is not enough to explain the importance of rights and suggests the addition of autonomy. As he explains:

One of Dworkin’s insights was to link Rawlsian contractarian theory to the language of rights. One of his failings was to fail to appreciate that both notions at the root of Kantian moral theory (equality and autonomy) were equally morally significant.¹⁹³

Freeman thus invokes Dworkin to bring in rights but argues that a plausible theory of rights requires the normative values at the root of the Rawlsian contractarian conception, equality *and* autonomy. This then leads into discussion of respecting those children who show themselves to be rational and autonomous: an interesting discussion but not one required here. Freeman is more concerned with *respecting* children and their autonomy, whereas arguing specifically for a child’s right to

¹⁸⁹ *ibid* 530.

¹⁹⁰ *ibid* 532.

¹⁹¹ *ibid* 532; see also, Rawls J, *A Theory of Justice* (n 12) 441-449.

¹⁹² Freeman MDA (n 181) 61.

¹⁹³ *ibid* 64.

healthcare I believe is more concerned with *protecting* children and their interests (a discussion undertaken in 2.1). Freeman does recognise the need for protection also, but this appears not to be her main concern:

We have to treat them as persons entitled to equal concern and respect and entitled to have both their present autonomy recognized and their capacity for future autonomy safeguarded. And this is to recognize that children, particularly younger children, need nurture, care and protection.¹⁹⁴

Freeman argues that we should respect children's autonomy except in circumstances where to do so would harm their future autonomy. He acknowledges that children's choices can have a deleterious impact on their life and that the reluctance to interfere with an adult's autonomy is not the same as with children. Dworkin also makes this point in *Paternalism*¹⁹⁵ when arguing that children often do not have an appropriate conception of present and future interests and find it very difficult to delay gratification. Because of this, Dworkin argues parents have a duty to restrict children's freedom,¹⁹⁶ but he adds the important moral limitation of future-oriented consent. In order to justify paternalism, the child must come to understand and welcome the steps taken as part of the long term goal of children becoming autonomous adults.¹⁹⁷

¹⁹⁴ *ibid* 66.

¹⁹⁵ Dworkin G (n 174).

¹⁹⁶ *ibid*; see also Appell AR, 'Uneasy Tensions Between Children's Rights and Civil Rights' (2004) 5 Nevada Law Journal 141.

¹⁹⁷ Dworkin G, (n 174) 75; see also Appell AR (n 196); This important limitation by Dworkin also helps separate children from the dilemmas of paternalism for those who suffer severe mental illness. One of the main problems for justifying paternalism of those who suffer learning difficulties or severe mental illness is drawing the line and stopping at those with mental conditions. The reasons for paternalism, such as protection for them because they would otherwise make bad decisions, can also be used to justify those who are more intelligent possessing paternalism over those with 'average' intelligence. Importantly, this debate can be circumvented because of the need for future-oriented consent. For children with mental conditions and learning difficulties who will not come to realise future-oriented consent, the initial paternalistic arguments are the same; that of protection because of their potentially bad decisions. But when they become adults, the debate shifts into finding justification for the arbitrary lines that will be drawn. This is not a discussion I shall go into; see Wikler D, 'Paternalism and the Mildly Retarded' (1979) 8 Philosophy & Public Affairs 377.

Freeman challenges those that would deny children's autonomy, stating "[t]he onus lies on those who wish to discriminate."¹⁹⁸ Those who would deny children respect of autonomy should provide the appropriate reasoning as to why they would do so, and respect for autonomy of *all* humans should be assumed absent such 'good reason'.¹⁹⁹ I agree with the onus being on those who would deny children respect of autonomy but believe justification for such discrimination can easily be found, especially for younger children, with Dworkin's argument of duty providing there is an appropriate moral limitation. This is not to deny such children rights, rather it is to change the basis of their rights; an argument made in chapter two. One potential problem with this approach is that paternalism could lead to a complete avoidance of childhood autonomy. As Freeman states, "[a]ll paternalistic restrictions require moral justification."²⁰⁰ For healthcare however, paternalistic restrictions, especially for younger children, are unlikely to be contentious.²⁰¹ Freeman suggests that the principles of justice "confine paternalism . . . without totally eliminating it,"²⁰² and argues those in the original position will know of the limited capabilities of others and it will be agreed therefore that some interventions are acceptable for protection

¹⁹⁸ Freeman suggests, as an example of the either/or for protection and autonomy, that the reasons for restriction of autonomy are not convincing because protection of children is poor. He argues the institutions we have now that are designed to protect children do not actually do so. This is a flawed argument however, at least the way it is used, because it is an attack on the institutions and the way they work, not on the reasons *for* those institutions in the first place. See, Freeman MDA (n 181) 66.

¹⁹⁹ *ibid.*

²⁰⁰ *ibid* 68.

²⁰¹ Of course capacity gradually increases and adolescences may achieve *Gillick* competency, yet I will not deviate and become distracted by discussion of the point that competency is gained mostly because international law is silent on the issue of child consent to medical treatment. There is mention of decisions that are taken being consistent with a child's evolving capacity in the CRC, article 5 and 14, but not more specific detail. See Hollingsworth K, 'Theorising Children's Rights in Youth Justice: The Significance of Autonomy and Foundational Rights' (2013) 76 *The Modern Law Review* 1046, 1060 who points out that the commitment to allow children to become fully autonomous is palpable in the denial of their right to refuse medical treatment that would be detrimental to their health. However, this is a side issue with difficult discussion itself with commentators comparing *Gillick* competency to the search for the Holy Grail; see Chell B, 'Competency: What It Is, What It Is Not, and Why It Matters' in Morrison EE, and Furlong B, (ed), *Health Care Ethics: Critical Issues For The 21st Century* (Third edn, Jones and Bartlett Learning 2014) 129; see Van Bueren G (n 65) 311; see also *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112 House of Lords.

²⁰² Freeman MDA (n 181) 67.

against irrational decisions and actions. Such actions may only be perceived as irrational however when it is manifest that they will “undermine future life choices, [and] impair interests in an irreversible way.”²⁰³ Such potential future detriment would undermine a person’s opportunities, something that would be most harmful to children as Freeman points out:

[W]e also would be failing to recognize a child’s integrity if we allowed him to choose an action, such as using heroin or choosing not to attend school, which would seriously and systematically impair the attainment of full personality and development subsequently.²⁰⁴

Thus Freeman’s theories align Dworkin’s thoughts of accepting a duty to be paternalistic but Freeman is perhaps slightly stronger with his concerns and need for its limitation. Nolan also agrees with Freeman’s confinement of paternalism, legitimising intervention only in the case of conduct which is irrational and to prevent immediate harm.²⁰⁵ In this way it can be seen how protecting children is important because of their future. Their capacities for rational choice, or their opportunities and future life choices are important and need to be protected. For now, I suggest a more direct appeal to Rawls’ theory can be made and may therefore provide a more convincing and powerful argument, certainly for the obligations of the State towards children.

4.3.4 Direct Application

Using similar methodology to Freeman in extending Dworkin’s thesis to children and defeating discriminating arguments, one can put the onus onto those who would

²⁰³ *ibid.*

²⁰⁴ *ibid.*

²⁰⁵ Nolan A, *Children’s Socio-Economic Rights, Democracy and the Courts* (Human Rights Law in Perspective, Hart Publishing 2011) 12.

discriminate²⁰⁶ and ask why would the principles of justice not be applied to children? Thus those who would argue that these principles would not be applied to children have to find the convincing arguments and reasons, yet this seems to be a challenge. For example, a claim that discrimination is justified because children are not contractors themselves, is addressed above by showing that children are clearly considered in the original position by the parties as well as rights bestowed on them that they may not understand in childhood but appreciate later on. An example of this is compulsory education (as mentioned by Freeman) despite children possibly not wanting to go to school, or preventive healthcare such as inoculations despite a child's protests: both are apt examples of 'future-oriented consent'.²⁰⁷ The idea is that the child would look back in the future and appreciate what was done. Both education and preventive healthcare can fall into this category, but so can the principles of justice as mentioned above.²⁰⁸

I maintain a more direct appeal to Rawls can be used, especially when Rawls agrees that children should be protected by the principles because of the necessary protection of their future. He argues;

[E]qual justice is owed to those who have the *capacity* to take part in and to act in accordance with the public understanding of the initial situation. One should observe that moral personality is here defined as a *potentiality* that is ordinarily realized in due course. It is this potentiality which brings the claims of justice into play.²⁰⁹

²⁰⁶ There is also evidence supporting such an idea in a historical legal context where restriction of such liberty must be positive in a famous case that effectively ended slavery in England and Wales; see *Somerset v Stewart* (1772) 98 ER 499, where Lord Mansfield found that slavery could not be supported through the common law but required positive law, a statute, and as this had never been actively undertaken, the slave must be freed. In comparison to rights for children it could be argued that equal rights should be assumed, and any restrictions must be justified through positive legal steps. The same applies morally to the principles of justice.

²⁰⁷ Freeman MDA (n 181) 68; see also Dworkin G (n 174).

²⁰⁸ Rawls J, *A Theory of Justice* (n 2) 119-120.

²⁰⁹ *ibid* 442 emphasis added.

A being that has this capacity, whether or not it is yet developed, is to receive the *full protection of the principles of justice*.²¹⁰

This is clearly intended to bring children who do not yet possess capacity within the scope of the principles of justice and to provide them with equal protection. The aim is to allow a fully autonomous person to develop and to do this requires equal justice, which means bestowal of the principles of it. The quote also mentions the basic rights of children, helping to show why a direct appeal to Rawls can establish rights and an ancillary invocation of Dworkin's singular right-based theory is not necessary.²¹¹

There is however, some further criticism for those individuals that lack capacity and, more poignantly, potential for gaining capacity. Nussbaum and others have pointed out the problem of social contract theories in giving people who have severe cognitive disabilities justice,²¹² which could include children and is clearly a concern for healthcare. If the focus of bestowing the principles of justice on children is potentiality, and those with severe cognitive disabilities do not have the potential to gain capacity, then this presents a serious problem for Rawls who does not seem to answer this problem.

It is contended here then that the needs of those with severe cognitive disabilities are to be dealt with at some point once the veil is lifted, but there is no thought about them in the original position, and as non-rational beings, they are not present themselves. Nussbaum complains that "[i]n effect, they are to be dominated, though

²¹⁰ *ibid* 445-446 emphasis added.

²¹¹ There is an unresolved issue that with Rawls' invocation of the potentiality argument, the theory would not allow abortion. This has been discussed by some authors but never resolved as an issue and do not wish it to side-track the thesis. See Evers WM (n 169); DiSilvestro R (n 164).

²¹² Nussbaum MC, *Creating Capabilities: The Human Development Approach* (The Belknap Press of Harvard University Press 2011) 87; see also Richardson HS, 'Rawlsian Social-Contract Theory and the Severely Disabled' (2006) 10 *The Journal of Ethics* 419; see also DiSilvestro R (n 164).

the domination is to be beneficent.²¹³ Rawls' dilemma here is not his emphasis on capacity as Nussbaum and Richardson²¹⁴ have mistakenly suggested, but as seen above, it is his emphasis on potential for capacity. Those without capacity are dealt with by Rawls when he considers children and their *potential* as being enough for equal justice. Yet the criticism is right that it is only at a later stage, when the veil is lifted, that people with severe cognitive disabilities will be considered, because they do not have such potential, thus making it difficult to see how the principles of justice can be applied to them. Whilst this is a disappointing element of Rawls' theory, and one which he failed to extensively engage with,²¹⁵ I am not convinced of its severely negative connotations.

Richardson explores the prospect of adding the thought of those with severe cognitive disabilities to the contractors in the original position, in a similar way to how children are considered, thus giving them concern and likely bestowal of the principles of justice. However, to do so Richardson changes the motivation of the contract so that the basic principles Rawls suggests would not be proposed behind the veil of ignorance.²¹⁶ Essentially Richardson alters the original position to add in the list of capabilities, proposed by Nussbaum and discussed later in section 4.4. This is an attractive and tempting way out of this dilemma, which others have considered,²¹⁷ but it is uncertain why Richardson changes the theory so much except to alter Rawls to fit his own desires.

The problem with this is that one of the main strengths of Rawls, its minimal, basic nature decided by ignorant yet rational parties, is lost. By adding in a specific list of what Nussbaum calls central capabilities, the theory becomes much more detailed,

²¹³ Nussbaum MC, *Creating Capabilities* (n 212) 87.

²¹⁴ Richardson HS (n 212).

²¹⁵ DiSilvestro R (n 164) 298.

²¹⁶ Richardson HS (n 212) 448.

²¹⁷ Barry B (n 12) 56-57; Brassington I (n 85) 13.

losing its minimal and likely universal appeal. More exploration of considering people with severe cognitive disabilities in the original position would have been useful, but it is contended that the principles would still be applied, especially with a quick glance at Rawls' words already seen in this thesis: ". . . as far as possible the choice of principles should not be influenced by arbitrary contingencies. Therefore it is reasonable to say that those who could take part in the initial agreement, were it not for fortuitous circumstances, are assured equal justice."²¹⁸ It is hoped to be acceptable that as it is, such individuals will be considered at a later point, once the veil is lifted and the principles become extended and interpreted. In this way Rawls' theory is not altered or changed in what could be a controversial manner, so only the natural extension of the basic principles needs to be explored.

Nussbaum and Richardson however, are quite critical of postponing consideration of those with severe disabilities as they believe when we do eventually consider them our basic ideas of justice will change.²¹⁹ If true, this could be very difficult as Rawls' principles would therefore be inadequate for our new ideas of justice which places a dilemma on Rawls' theory as there will be no way of changing the principles. If individuals, with the new ideas of justice, decide to go behind the veil afterwards, which is one of the main strengths of Rawls' theory, their ignorance will be the same as it was before they considered those with severe disabilities and thus the principles agreed to will also be the same. Richardson sums up the general arguments Nussbaum puts forward against postponement;

1. *The pervasiveness of dependence and disability*
2. *The universality of care*
3. *The continuum of disability*
4. *The moral imperative to avoid drawing a dichotomy between the disabled and the non-disabled*²²⁰

²¹⁸ Rawls J, *A Theory of Justice* (n 12) 446.

²¹⁹ Richardson HS (n 212) 420; see also Nussbaum MC, *Creating Capabilities* (n 212).

²²⁰ Richardson HS (n 212) 421. "1. Each of us enters life as a dependent infant lacking the capabilities of a fully cooperating member of society, almost all of us get seriously ill at some

The problem as I see it is that none of these points are very convincing. The prominence of dependence and disability is not evidence of a problem if its consideration is only to be at the constitutional (post veil) phase of discussion for example. In fact, such prominence will mean that consideration will likely occur at the earliest possible stage, just not behind the veil of ignorance. The universality of care offered above proposes nothing to the debate; it is merely a comment on human life and not a consideration of justice. The continuum of disability is similar and ties in with the fourth point about drawing a dichotomy. Whilst it may be that there is a continuum, and I certainly share the objection to the idea of a dichotomy, such idealism can never be realised. A line has always been, and will always be, drawn somewhere by the legislature for people with severe cognitive disabilities in order to protect them and/or others.²²¹ Often their autonomy is restricted and things are done in their best interests in a similar way to children. These things are decided by rational adults, therefore creating an unavoidable dichotomy simply by deciding who receives extra benefits and support for their disability.

However Nussbaum is correct that modifying Rawls' theory to deal with the issue of justice and disability is not easy.²²² Any thought after the original position does not make such consideration one of fundamental justice, yet there are two ways already proposed that this could be rectified. Firstly is the extension by Richardson, briefly explored, that the contractors would acknowledge the possibility of those with severe cognitive disabilities in the original position, in much the same way as children. And secondly, whilst for children I argued such circumvention was

point, and many of us will be infirm and dependent again in old age. 2. Correspondingly, care-giving work by parents (most often mothers), doctors and nurses, and by one's children or the state is an essential feature of human life. 3. Each of us has capabilities that are defective in one way or another. There is a continuum (although not a clearly ordered one) in this regard. 4. Given the appalling history of social treatment of those with serious disabilities, it would be wrong to approach these issues with an "us" and "them" mentality."

²²¹ See for example UK Mental Capacity Act 2005.

²²² Richardson HS (n 212) 421; Nussbaum MC, *Frontiers of Justice: Disability, Nationality, Species Membership* (The Belknap Press of Harvard University Press 2006) 18.

unnecessary, appealing to Dworkin and then Freeman can extend Rawls by ensuring a fundamental right to *all* citizens to equal concern and respect. However, consideration after the original position will still ensure basic rights, protection and respect to people with severe cognitive disabilities.

Richardson does express one practical concern about applying the principles of justice to the disabled, specifically, that “providing equal opportunity for the more disabled is relatively difficult, and since the more disabled are likely to be among the least advantaged members of society, this interpretive shift has radical practical implications.”²²³ It is clear that not all groups will or should be treated the same in fulfilling the principles of justice and that is why as part of fulfilling equality of opportunity for children, education will be guaranteed, whereas it will not be for adults.²²⁴

Children are different, since we are trying to promote the development of adult capabilities. . . . we must always justify coercive treatment of children with reference to the adult-capability goal.²²⁵

Once the veil is partially lifted, in deciding what children require, different principles will carry different weight. It certainly would seem that the most important principle for children that will perhaps lead to the most rights and guarantees is the second principle and more particularly the equality of opportunity. It cannot be contentious to suggest that the generation which requires the most opportunity once the veil is lifted is that of children, who have their whole lives ahead of them and have yet to consider who or what they want to become.

That the principles of justice are bestowed on children is a powerful theory that need not be more complicated than that. Equality of opportunity is the vital principle for

²²³ See, Richardson HS (n 212) 443.

²²⁴ Rawls J, *A Theory of Justice* (n 12) 63, 86-87, 243-247, and 265.

²²⁵ Nussbaum MC, 'Capabilities and Human Rights' (n 12) 291; see also Dixon R, and Nussbaum MC (n 159) 561; Nussbaum MC, *Creating Capabilities* (n 212) 26.

children it is enough that healthcare is very much in the interests of children and a right that should be bestowed upon them. Up until now discussion has very much focused on the areas of Rawls that are generally agreed with and defended and the bestowal of a minimal theory of justice upon children. In the next chapter arguments move to the areas of Rawls that are not as well accepted, and where new ideas have been proposed. How the theory applies in a global setting shall be addressed and it will be seen that Rawls' own scant ideas on the topic do not follow his earlier theory and following the earlier work is more than palatable to find global justice.

4.4 An Alternative Theory?

The capabilities approach is a “new theoretical paradigm in the development and policy world [which] begins with a very simple question: What are people actually able to do and to be? What real opportunities are available to them?”²²⁶ Nussbaum says the approach is a “comparative quality-of-life assessment”²²⁷ and a theory of basic social justice focusing on choice, freedom, and the real opportunities available to each person. “It [also] ascribes an urgent *task to government and public policy* – namely, to improve the quality of life for all people, as defined by their capabilities.”²²⁸ Sen and Nussbaum differ slightly in that Sen focuses on the idea that capability is the best ‘space’ for quality-of-life assessment and discussion and he does not provide a definitive list of capabilities. Sen also focuses on the idea of

²²⁶ Nussbaum MC, *Creating Capabilities* (n 212) x.

²²⁷ *ibid* 18.

²²⁸ *ibid* 19 emphasis in original.

capabilities as freedom and agrees with Rawls' priority of liberty.²²⁹ This approach is criticised by Nussbaum because it is seen as a general good without considering that some freedoms are bad, and that all societies pursuing equality and social minimums restrict freedom in some ways.²³⁰ This is part of Nussbaum's justification for focusing on a core group of entitlements as she instead structures a basic theory of social justice and composes a specific list of *Central Capabilities* necessary for a life worthy of human dignity.²³¹

For Sen, capabilities "are not just abilities residing inside a person but also the freedoms or opportunities created by a combination of personal abilities and the political, social, and economic environment."²³² Nussbaum argues for a focus on human development, dignity and equality by governments, non-governmental organisations, businesses and multi-national corporations. However, the main task of securing at least a threshold level of these capabilities, falls on to governments to allow for a dignified and minimally flourishing life, and Nussbaum proposes a list of ten central capabilities that, as a bare minimum, are necessary for a life worthy of human dignity.

4.4.1 A Minimal Theory?

"[G]overnment is accountable for the presence of the ten capabilities on my list, if the nation is to be even minimally just."²³³ Nussbaum argues that her list of capabilities is minimal, yet given the long list and detail she adds, this seems

²²⁹ Nussbaum MC, 'Capabilities and Human Rights' (n 12) 277; Sen A, 'Freedoms and Needs' *New Republic* (01/10/1994) 31-38.

²³⁰ Nussbaum MC, *Creating Capabilities* (n 212) 70-73.

²³¹ *ibid* 19.

²³² *ibid* 20.

²³³ *ibid* 64.

unconvincing.²³⁴ The list includes plenty of very specific freedoms which could be covered by Rawls' first principle of liberty, which could be seen as similar to Sen's more general freedom. Nussbaum has criticised this, but unlike Sen, Rawls' liberty principle is allowed to be restricted, if only for the sake of liberty, as previously discussed in section 4.1.2. Nussbaum also includes some capabilities that seem strange because it would seem rather peculiar to place them at the fundamental

²³⁴ *ibid* 33-34; The list she proposes is;

1. *Life*. Being able to live to the end of a human life of normal length; not dying prematurely, or behave one's life is so reduced as to be not worth living.
2. *Bodily health*. Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.
3. *Bodily integrity*. Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.
4. *Senses, imagination, and thought*. Being able to use the senses, to imagine, think, and reason – and to do these things in a “truly human” way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experience and producing works and events of one's own choice, religious, literary, musical and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to have pleasurable experiences and to avoid nonbeneficial pain.
5. *Emotions*. Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by fear and anxiety. (Supporting this capability means supporting forms of human association that can be shown to be crucial in their development.)
6. *Practical Reason*. Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience and religious observance.)
7. *Affiliation*. (A) Being able to live with and towards others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech.) (B) Having the social bases of self-respect and nonhumiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of non-discrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, national origin.
8. *Other species*. Being able to live with concern for and in relation to animals, plants, and the world of nature.
9. *Play*. Being able to laugh, to play, to enjoy recreational activities.
10. *Control over one's environment*. (A) *Political*. Being able to participate effectively in political choices that govern one's life; having the right of political participation, protections of free speech and association. (B) *Material*. Being able to hold property (both land and movable goods), and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers.

level of being necessary for dignity. For instance, “being able to live with concern for and in relation to animals, plants, and the world of nature”,²³⁵ whilst important in many ways, is not something which may be considered necessary to securing a life of human dignity given some of the problems facing the world. Therefore, as mentioned, I question the minimal nature of Nussbaum’s capabilities and that is part of the justification for my focus on Rawls.

4.4.2 Opportunity or Capability?

Daniels also suggests that there are not really any important differences between Rawls theory of justice and the capabilities approach. The argument by Daniels can once again be summed up by a relatively simple question: what exactly is the difference between capabilities and opportunities?²³⁶ Sen and Nussbaum argue that the important target of justice is to ensure people have equality of capabilities, as opposed to the primary social goods that Rawls proposes, of which equality of opportunity is only one. Nussbaum criticises Rawls’ ‘resource-based approach’ and the focus on the primary goods because she believes it is egalitarian to the GDP approach (which she rightly criticises for focusing on overall wealth at the top and not considering development, capabilities, or what those at the bottom have). However, it is telling that Nussbaum only focuses on the primary social goods of income and wealth, and at no point mentions or discusses rights, liberties, or opportunities.²³⁷ To completely ignore Rawls principle of equality of opportunity, and state that a key strength of the capabilities approach is that it asks what people can

²³⁵ *ibid* 34.

²³⁶ Yamin AE (n 4) 47, for example Yamin argues we are concerned with preserving the normal opportunity range, or achieving their capabilities. Discussing these in the same sentence as the reasons to why we value health clearly shows their similarity.

²³⁷ Nussbaum MC, *Creating Capabilities* (n 212) 56-58.

really do or be, is to misrepresent and misunderstand what Rawls more complete, yet minimal theory can achieve.

Daniels argues that, especially given the extension of Rawls that he provides, the difference between capabilities and opportunities barely exists. "Meeting health needs is crucial to sustaining capabilities for the same reason that it is crucial to protecting a fair share of the opportunity range: Normal functioning is critical to both."²³⁸ To be capable of doing something, one must have the opportunity to do it, and to realise an opportunity, one must be capable of achieving it. Lennart Nordenfelt argues along similar lines with his focus on health as an ability to achieve vital goals in one's life.²³⁹ Vital goals are what one holds most essential in life and health is the possession of necessary abilities to realise such goals.²⁴⁰

It could even be suggested that, given the extension of Rawls' opportunity principle, the ten *Central Capabilities* Nussbaum proposes would fit into such an extension and could be decided upon once the veil of ignorance is lifted. "The [capabilities] approach is therefore very similar to Rawls's approach using the notion of primary goods. We can see the list of capabilities as like a long list of opportunities for life-functioning, such that it is always rational to want them whatever else one wants."²⁴¹ Such an idea is also more attractive than Richardson's blending of the two theories²⁴² as it maintains the basic and more minimal Rawlsian argument, yet uses the strength of the capabilities approach suggesting the list maybe added in the subsequent three stages once the veil is lifted.

For the purposes of this thesis it is enough to demonstrate that opportunities and capabilities are irreversibly connected, and for the purposes of justice and the

²³⁸ Daniels N *Just Health* (n 1) 64.

²³⁹ Nordenfelt L, 'The concepts of health and illness revisited.' (2007) 10 *Medicine, Health Care and Philosophy* 5, 7.

²⁴⁰ *ibid.*

²⁴¹ Nussbaum MC, 'Capabilities and Human Rights' (n 12) 290.

²⁴² Richardson HS (n 212).

requirement of the provision of healthcare, they are very similar. For example, in the literature, they are often interchangeable, as seen by Nussbaum and Sen themselves:

Notions of equal *opportunity* certainly have an important role to play in a [capabilities approach]. *The very idea of capability is an idea of substantive opportunity*²⁴³.

What is particularly serious as an injustice is the lack of *opportunity* that some may have to achieve good health . . . This calls for the further distinction between health achievement and the *capability* to achieve good health.²⁴⁴

So in the discussion of healthcare, not only are opportunity and capability interchangeable, but Sen also shows the importance the capabilities approach places on meeting health needs. Nussbaum also includes health on her list of ten *Central Capabilities*,²⁴⁵ thus as Daniels says, prominent theories find an obligation to provide healthcare even if for slightly different reasons.

4.5 Concluding Remarks

Having considered competing theories, the intention of this thesis is to seek a solution to the problems discussed in Part A by focusing primarily on that of Rawls because it is the most fully developed general theory of justice providing an argument for fair equality of opportunity, which informs the obligations of the State. That Rawls provides a more complete theory is also accepted by Nussbaum when she suggests that there are many areas that are not covered by the capabilities

²⁴³ Dixon R, and Nussbaum MC (n 159) 571 emphasis added.

²⁴⁴ Sen A, 'Why health equity?' (2002) 11 Health Economics 659, 660 emphasis added.

²⁴⁵ Nussbaum MC, *Creating Capabilities* (n 212) 33.

approach and still need to be discussed in the future such as, how inequalities above the minimum threshold demanded by the theory should be handled.²⁴⁶ Rawls answers such queries with the difference principle: inequalities, particularly in income and wealth, are only permitted as long as they make the worst off better off than they otherwise would be with complete equality. Rawls' theory is also the most minimal theory of justice that is pragmatic in that it accepts the world as we have it now with developed States, thus it stands a much greater chance of being universally acceptable and provides a jurisprudential foundation for practical discussion of current law. Finding an obligation to provide at least basic healthcare even within such minimal principles, serves to strengthen the argument of a State's duty to ensure every child has access to healthcare. Having established the credibility of such an argument this thesis will now focus on addressing Daniels' challenge to the next generation of academics. It has been seen from Daniels' extension that justice requires the reduction of domestic health inequalities as the obligations of the State have clearly been established. However Daniels wants others to pursue international obligations and assistance beyond State borders, yet between strong statist ideas that social justice is the singular responsibility of the State, and cosmopolitan claims that the principles apply to individuals regardless of borders and institutional design.²⁴⁷ Navigating this difficult gap, and bringing these moral arguments into pragmatic international legal debate, is the ultimate aim of this thesis.

The argument thus far in Part B has been a focus on Rawls' theory of justice as it stands, claiming that this strong yet minimal theory can find a child's right to healthcare as a moral, State obligation. Now this has been established, discussion moves on to areas of extending the work so far. Chapter five therefore advocates

²⁴⁶ *ibid* 40.

²⁴⁷ Daniels N *Just Health* (n 1) 346.

for the globalisation firstly of Rawls' work, something he himself disagreed with; and secondly, the appropriate way to adjudicate the right to healthcare.

Chapter Five

A Global Theory

The previous chapter laid out John Rawls' theory of justice and effectively established that children have a place in a Rawlsian society and the protection of the two principles of justice should be bestowed on them, which, via a natural extension of equality of opportunity, in turns leads to a right to healthcare. Whilst an important underpinning, this last chapter does not by itself apply those obligations that are found in a global setting. Extending Rawls' theory, along with the idea of adjudicating such rights for effective enforcement, to a global setting, is what this chapter sets out to achieve. First the global picture and the application of Rawls' theory will be discussed. Rawls himself has stated that his theory does not apply universally but rather only to small societies, which in modern day practice means States as we know them. As a thesis that largely accepts Rawls' theory of justice, it is necessary to explain Rawls' own international perspective in *The Law of Peoples* to show why the original authors own extension is not used. It will be shown how much criticism this opinion of Rawls about his own theory has received in the literature from many advocates of Rawls' original *Theory of Justice*. Whilst accepting the overarching principles of his theory discussed above, it will be shown that Rawls' own extension of his theory to a globalised world is found wanting. It is argued strongly that application of his theory of justice to the global milieu is not merely advantageous for the purposes of this thesis, but is also a basic premise of his initial theory, something Rawls himself failed to realise.

After establishing the globalised nature of this theory, the lessons in chapter three will be brought together to propose a framework for international jurisprudence on the right to healthcare. It is argued that adjudication through international courts

could provide strong enforcement mechanisms which are presently lacking, as seen in chapter two, and yet if such a proposal is to be undertaken, it must be done carefully and appropriately avoiding some of the more contentious methods used which have led to contempt of court proceedings. The globalisation of this thesis requires that the fundamental obligations found, which by extension include healthcare services, are the focus and responsibility of the entire world. This informs discussion on international human rights, their enforcement, their international adjudication and the global redistribution of resources to be discussed throughout the remaining chapter of the thesis.

5.1 Globalising Rawls

The key to globalising Rawls' theory of justice lies, I believe, with the work of Thomas Pogge and Charles Beitz.¹ As mentioned in the introduction to this chapter, Rawls' own idea of extending his theory to international relations and a global theory of justice has been criticised and Pogge and Beitz are amongst the critics who propose a different method which is a much more natural extension. Firstly it is necessary to present Rawls' ideas whilst also critiquing them in order to justify not using the authors own perspective of his theory. After this the appropriate globalisation of Rawls' theory of justice as proposed by Beitz, and, more specifically for this thesis, by Pogge, shall be discussed.

¹ Pogge T, *Realizing Rawls* (Cornell University Press 1989), see also Pogge T, *World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms* (Second edn, Polity Press 2008); Beitz CR, *Political Theory and International Relations* (Princeton University Press 1979); Beitz CR, 'Rawls's Law of Peoples' (2000) 110 *Ethics* 669.

5.1.1 The Law of Peoples

5.1.1.1 The Second Original Position

In the *Law of Peoples*, Rawls uses similar arguments to those seen in previous work, as highlighted in the last chapter and proposes the use of a *second* original position. The parties in this 'second' original position are behind a slightly different veil of ignorance and now represent liberal peoples. Rawls reiterates that the original position with a veil of ignorance is a model of representation which again prevents parties involving inappropriate reasoning.² In this second original position, the representatives are to specify the Law of Peoples; an agreement on justice between societies and based on the liberal conception of justice already chosen in the first original position.³ There will again be a basis of equality of peoples and not of primary social goods. This veil of ignorance is "properly adjusted for the case at hand"⁴ meaning the parties do not know certain facts such as the size of their territory, population, strength of their people, natural resources or economic development. They do know however, that reasonably favourable conditions apply as they know they represent liberal societies and thus will have constitutional democracy. The second original position then is a model of representation in exactly the same way as the first, creating features we would accept as fair in determining the basic terms of cooperation among peoples who see themselves as free and equal. The difference between the first and second original positions is not in how

² See Section 2.1.1.

³ Rawls J, *The Law of Peoples with "The Idea of Public Reason Revisited"* (Harvard University Press 1999) 33 and 41; see also Boucher D, 'Uniting What Right Permits with What Interest Prescribes: Rawls's Law of Peoples in Context' in Martin R, and Reidy DA (ed), *Rawls's Law of Peoples: A Realistic Utopia?* (Blackwell Publishing 2006) 31.

⁴ Rawls J, *The Law of Peoples* (n 3) 32.

they are used but how, as a model of representation, they need to be tailored differently for the parties and subject at hand.⁵

In turning to the actual principles of the Law of Peoples, Rawls follows Kant in *Perpetual Peace*⁶ in that the principles will make room for cooperative organisations and institutions but will not lead to a world-State that would mean either global despotism or a fragile empire continuously torn apart by civil struggles. Rawls' cooperative organisations do however envision a United Nations type of organisation with authority to condemn unjust domestic institutions and violations of human rights and use economic sanctions and military intervention in extreme cases.⁷

Rawls then lays out his admittedly incomplete list of eight principles and points out that others will need to be added. The most interesting and relevant for this thesis are:

Peoples are to observe treaties and undertakings.

Peoples have to honor human rights.

Peoples have a duty to assist other peoples living under unfavorable conditions that prevent their having a just or decent political and social regime.⁸

⁵ The differences are however quite subtle and Rawls checks that the five essential features of any original position are still covered by the slightly altered second-level: the representatives are fair, free and equal; they are rational; deliberate correct subjects; deliberations are correct; and principles are based on their fundamental interests. Peoples being so reasonable and rational means that in the second original position they will offer fair terms of political and social cooperation which all will uphold even when it may be beneficial for them not to do so. In this way, "the criterion of reciprocity applies to the Law of Peoples in the same way it does to the principles of justice for a constitutional regime." *ibid* 33-35.

⁶ Kant I, *Perpetual Peace: A Philosophical Essay* (George Allen and Unwin Ltd 1795).

⁷ Rawls J, *The Law of Peoples* (n 3) 36.

⁸ *ibid* 37; see the full list; 1. Peoples are free and independent, and their freedom and independence are to be respected by other peoples. 2. Peoples are to observe treaties and undertakings. 3. Peoples are equal and are parties to the agreements that bind them. 4. Peoples are to observe a duty of non-intervention. 5. Peoples have the right of self-defense but no right to instigate war for reasons other than self-defense. 6. Peoples have to honor human rights. 7. Peoples are to observe certain specified restrictions in the conduct of war. 8. Peoples have a duty to assist other peoples living under unfavorable conditions that prevent their having a just or decent political and social regime.

Much like the first original position the parties begin with equality, but the second time it is equality and equal rights of all peoples as opposed to primary social goods.⁹ Rawls contends that he has taken the eight principles from “the history and usages of international law and practice.”¹⁰ Unlike the first instance, the parties are not given alternative principles and ideals from which they have to choose but they reflect on the eight principles and see no reason to seek alternatives or not to accept them. Any alternatives that might be thought of would be rejected by liberal peoples so it is more the interpretation of these eight principles that is discussed in the second original position.¹¹

5.1.1.2 Problems of the Second Original Position

One major criticism in the literature of Rawls’ theory is that of the second original position and the problems it creates. Firstly it has been argued that it would lead to excessive inequalities that would not be immediately obvious. In a similar way to the domestic theory and being concerned with the worst-off individuals because these could be themselves, they would be concerned with their position and would remain naturally risk-averse. Splitting the concern between the two original positions however, means that the resultant excessive inequalities may not be realised, as Pogge explains:

[S]uppose income inequalities are constrained by a ratio of 30:1. . . . Income in the poorest state (with per capita gross national product of 200) might vary between 360 and 12, while in the richest state (with a per capita gross national product of 6,000) the spread is between 60,000 and 2,000. Imposing two separate 30:1 limitations comfortably permits inequalities of 5,000:1 (a spread of 60,000 to 12).¹²

⁹ *ibid* 40.

¹⁰ *ibid* 41.

¹¹ *ibid* 42.

¹² Pogge T, *Realizing Rawls* (n 1) 253.

Thus two original positions instead of one and separate considerations create gross inequalities we would find unacceptable and which will also affect the bargaining power of peoples leading to further economic problems and pressure,¹³ discussed in more detail below.

The second problem with two original positions which Pogge highlights is that at the start of the second, the parties must realise that their society is not a closed and self-sufficient one as first thought, but part of some multinational scheme.¹⁴ The problem with this, Pogge suggests, is that the parties will then come to regret their choices in the first original position. He argues that they would naturally consider the globally worst-off social position when assessing all basic institutions, because of their concern for the economic strength of their own people, thus they would want to substitute their prior domestic agreement for one where the basic institutions are governed by the two principles of justice, but interpreted globally.¹⁵

A third problem that is highlighted with the second original position is that it assumes priority of the domestic situation as it occurs before the international one.¹⁶ If the domestic original position takes place first and is then complemented by the international case, then there is an assumption that the national basic structure can be developed without considering the international system within which peoples exist, which is implausible and unnecessary.¹⁷ When considering such a scheme consideration should be given to the international scheme rather than assuming national isolation.¹⁸ Both national and international basic structures have a strong impact on each other, on their stability, and they are closely interrelated so Pogge argues we should consider the basic structure from a global point of view to aim for

¹³ Beitz CR, *Political Theory and International Relations* (n 1) 147.

¹⁴ Pogge T, *Realizing Rawls* (n 1) 254.

¹⁵ *ibid.*

¹⁶ Hayden P, *John Rawls: Towards a Just World Order* (Political Philosophy Now, University of Wales Press 2002).

¹⁷ Pogge T, *Realizing Rawls* (n 1) 255.

¹⁸ *ibid* 255.

integration whilst ensuring distribution that is fair globally and nationally. This leads naturally to arguments for global social cooperation,¹⁹ and a “single unified original position global in scope”²⁰ will be discussed in the next section.

Finally, Pogge also criticises the flexibility Rawls has given to the original position in using a slightly different second one in establishing his Law of Peoples. Pogge argues that because the original position is so flexible this makes the desired conclusions unremarkable if you can change the rules to anything that will give you the answer you want,²¹ thus removing one of the main strengths behind Rawls’ thick veil of ignorance. In the international case, the rules are endorsed directly in the second original position and with little option for different interpretations or institutional design to find the best method of achieving the aims of the rules.²² Internationally the direct question leads to an inflexible response. This in turn leads to the consequence of past decisions by previous members of the society being borne by its present members. Pogge points out that some societies feeling the full consequences of unfortunate past decisions or unfortunate natural circumstances is unjust and punitive to those who had no say or role in the decisions made, especially children, for example.²³ This problem is addressed domestically with the flexibility allowed post veil and the difference principle which requires some burden sharing, yet this is denied internationally for reasons that are unclear. The more rigid Law of Peoples, is completely unchecked by any general rules, principles, boundaries or expectations, and does not allow for arguments of substantial change in the global economic order. Pogge highlights this problem and states that Rawls’

¹⁹ Beitz CR, *Political Theory and International Relations* (n 1) 132.

²⁰ Pogge T, *Realizing Rawls* (n 1) 256.

²¹ Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' in Martin R, and Reidy DA (ed), *Rawls's Law of Peoples: A Realistic Utopia?* (Blackwell Publishing 2006) 211 – 212.

²² *ibid* 213-214. In designing the economic order, domestically Rawls’ theory gives this flexible response beyond the veil, which ensures equal liberty and equality of opportunity. Beyond these assurances various ideas can be put forward that would generally increase the socioeconomic floor.

²³ *ibid* 215.

economic order is based on unconstrained free bargaining which allows stronger societies to shape the terms to their own advantage.²⁴

More on this problem of free bargaining in creating the global economic order will be discussed below as this has helped create the current economic order which leaves many countries without enough to afford minimum basic healthcare even if the policies and aspirations were in place. As seen in chapter one, there is the tragic irony that the richest country in the world and largest benefactor of the free bargaining which created the current unjust economic order²⁵ does not have appropriate policies in place to ensure a minimum standard of healthcare for every child. Returning to the critique of Rawls, the reasons behind the use of peoples must be considered which Rawls argues provides moral character, although this has been criticised as being at odds with his earlier work.

5.1.1.3 Peoples not States

Rawls' *The Law of Peoples*²⁶ applies a "political conception of right and justice . . . to the principles and norms of international law and practice."²⁷ With Rawls looking to the norms of international law and practice, an obvious question which arises is why the Law of *Peoples* and not States? Rawls realises this question and spends some time justifying his title. Peoples cannot be any random collection of persons but must be related to each other in such a way that their society is well-ordered. These necessarily liberal peoples will also have a commonality between them and about how affairs should be ordered. Rawls argues that liberal peoples have three

²⁴ *ibid* 217.

²⁵ D'Souza C, 'World Constitutionalism' in D'Souza A, and D'Souza C (ed), *World Constitutionalism* (Cambridge Scholars Publishing 2007) 1.

²⁶ Inspired by Kant's *Perpetual Peace* (n 6); Rawls J, *The Law of Peoples* (n 3) 10; see also Boucher D (n 3) 19.

²⁷ Rawls J, *The Law of Peoples* (n 3) 3.

basic features: a just constitutional democratic government serving their basic interests; citizens united by common sympathies; and a moral nature.²⁸ Thus firstly, peoples have a government that is under their own political and electoral control, and is not an autonomous agency that is directed by private interests free from accountability.²⁹

Secondly, Rawls argues that peoples must possess common sympathies and are more than just a collection of individuals.³⁰ Peoples have an *amour-propre* which is one of their main distinguishing features from States and is a proper self-interest according to Rawls.³¹ This is a self-love based on their common history and achievements and helps create a people's identity. This is what will lead them to demand that other just peoples treat them as equals with proper respect and make them treat others the same.³²

Finally the moral character of peoples means they are reasonable and rational and as such will "offer fair terms of cooperation to other peoples. A people will honor these terms when assured that other peoples will do so as well. This leads to the principles of political justice in the first case and the Law of Peoples in the other."³³

People's self-interests are limited much more than that of States, to what is

²⁸ *ibid* 23; "common sympathies" is taken from J. S. Mill's *Considerations* (1862).

²⁹ *ibid* 24. This basic structure of a people will mean that the coercive decisions by their governments will have to be justified. Such coercion is inevitable and in Law of Peoples Rawls is concerned with legitimising global coercion rather than focusing on the fate of individual citizens in different countries. This is one of the main areas where he differs from cosmopolitans, discussed below, and also ties Rawls Law of Peoples much more closely to his *Political Liberalism*, than to *A Theory of Justice*. See, Pettit P, 'Rawls's Peoples' in Martin R, and Reidy DA (ed), *Rawls's Law of Peoples: A Realistic Utopia?* (Blackwell Publishing 2006) 44; see also, Wenar L, 'Why Rawls is Not a Cosmopolitan Egalitarian' in Martin R, and Reidy DA (ed), *Rawls's Law of Peoples: A Realistic Utopia?* (Blackwell Publishing 2006) 95.

³⁰ Audard acknowledges what a controversial point this is, as in spite of the possible constitutive elements of people being even contradictory, historical or linguistic commonality for example is enough to create a definitive moral nature and make them peoples. See, Audard C, 'Cultural Imperialism and 'Democratic Peace' in Martin R, and Reidy DA (ed), *Rawls's Law of Peoples: A Realistic Utopia?* (Blackwell Publishing 2006) 67.

³¹ Rawls J, *The Law of Peoples* (n 3) 34; see also Boucher D (n 3) 32.

³² Boucher D (n 3) 32.

³³ Rawls J, *The Law of Peoples* (n 3) 25.

reasonable, which therefore limits the power of sovereignty.³⁴ It is argued that the law of peoples would deny the traditional unrestricted autonomy of the State because peoples and States are not the same because of people's moral status.³⁵

Rawls points out that the basic features of peoples indicated above and the distinction from traditional sovereignty justifies the use of peoples and not States.

The term "peoples," then, is meant to emphasize these singular features of peoples as distinct from states, as traditionally conceived, and to highlight their moral character and the reasonably just, or decent, nature of their regimes.³⁶

States still struggle for power, prestige and greater wealth whereas liberal peoples limit their interests and they are fully prepared to grant respect and recognition to other peoples as equals.³⁷ This final interest is peoples' insistence on respect from, and equality to, other peoples which is a crucial difference to States.³⁸

³⁴ Boucher D (n 3) 22.

³⁵ Indeed Tan has suggested that the Law of Peoples is the law of nations that are capable of having a sense of justice; that peoples are an idealised nation-State. Rawls wants his peoples to have a moral character so he can reject States as conceived by realism. Rawls also supports human rights in the *Law of Peoples* and points out that since World War II they are an obvious connection to the effort to limit a government's internal sovereignty. Rawls supports a very minimal approach to human rights and talks of human rights proper being a subset of his first principle of justice. Hinsch and Stepanians support this somewhat by accepting that there are certainly more human rights than could reasonably be the universal moral standards and argue this 'unprincipled proliferation' is what has led to people to seek more austere human rights approaches. Beitz disagrees and argues that human rights do much more defining the standards expected for a state and are our shared goals of political reform. Tan K-C, 'The Problem of Decent Peoples' in Martin R, and Reidy DA (ed), *Rawls's Law of Peoples: A Realistic Utopia?* (Blackwell Publishing 2006) 77-79; Rawls J, *The Law of Peoples* (n 3) 27; Articles 3 to 18 of the Universal Declaration of Human Rights; Hinsch W, and Stepanians M, 'Human Rights as Moral Claim Rights' in Martin R, and Reidy DA (ed), *Rawls's Law of Peoples: A Realistic Utopia?* (Blackwell Publishing 2006) 125-126; Beitz CR, 'Rawls's Law of Peoples' (n 1) 687.

³⁶ Rawls J, *The Law of Peoples* (n 3) 27.

³⁷ *ibid* 28-29 and 35.

³⁸ Rawls however also contends that the difference from States does not mean that some inequalities will not be accepted and may be agreed to in certain cooperative institutions in a similar way to the difference principle, as a way of recognising functional social and economic inequalities. This is an important point to which I shall return as it seems to suggest a difference principle in global institutions which if put in practice could make a large impact on the current global economic structure and to those at the bottom; *ibid* 35.

5.1.1.4 Difficulty of Peoples

Pogge suggests the use of *peoples* is difficult because if its use is based on the moral valuation of peoples then it disagrees with Rawls' own theory of justice which provides no moral reason for valuing political boundaries and therefore the *people* that Rawls puts in the international original position. The alternative possibility is that *peoples* reflects facts of the world and is designed to be realist and pragmatic, although this is doubtful as Rawls makes no effort to justify this point. Indeed it is suggested that this cannot be the case as peoples are States with moral and cultural character. Rawls wishes to work within the confines of idealised States and reject States conceived by realism.³⁹ Therefore Rawls fails to adequately justify his use of peoples as it contradicts his own theory of justice and cannot be a realist approach.

Another problem Pogge highlights with the use of peoples is its lack of definition. It is unclear what groups are considered people and how this is to be decided. Do we isolate them in States? Such as Britain? Or England? People from Manchester? Christians? Catholics? All of these groups could be considered peoples within the theory, and there is a further clear problem that someone could easily fall into more than one definition of peoples, such as the author falling into all of the above suggestions.⁴⁰

Thirdly, there is a problem of flexibility of the original position and changes to the consideration of individual interests, creating a difference between the domestic and international theories with moral weight given to individuals in the domestic instance, which is ignored in the international case. With collectives and associations, for example, the reverse is true in that they are not considered to have moral weight in

³⁹ Tan K-C (n 35) 77.

⁴⁰ Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21) 211.

the domestic case. Pogge pointed out from an early stage that Rawls' ideas on peoples disagreed with a central point of his previous theory of justice; the focus on the basic structure and conception of all human beings as free and equal moral persons.⁴¹ The obligation by rich peoples to help those burdened societies that may become liberal or decent is only to the absolute minimum necessary and Pogge points out that this is because there is no thought given to the interests of individuals in the law of peoples; otherwise the obligation of the rich would go further and not aggravate the stark economic inequalities we have now.⁴² Rawls argues that disregarding individual interests in the international theory is necessary to accommodate the decent (non-liberal) societies he wishes to include.⁴³ Pogge disagrees stating that "[a]ccommodating decent societies is . . . necessarily compatible with incorporating into the international original position a concern for at least the jointly recognized interests of individuals, alongside the interest of each people in maintaining a stable well-ordered domestic regime."⁴⁴ Pogge also argues that incorporating individual interests could have an impact on forming the rules for good conduct of States, such as avoiding severe poverty.⁴⁵ Thus Rawls' justification for failing to include individual interests in the international theory fails. Pogge argues the individualistic nature of Rawls' initial theory of justice should not and cannot be removed and ignored and indeed should, in using Rawls' earlier conception of background justice, lead to an "interpretation of the original position on which the global parties represent persons and therefore assess a global institutional scheme by the worst representative individual share it tends to produce."⁴⁶ Pogge's ideas on this will be discussed more below, yet the global

⁴¹ Pogge T, *Realizing Rawls* (n 1) 240.

⁴² Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21) 211.

⁴³ Lack of moral status to non-liberals is one criticism levelled at the cosmopolitan theories of Pogge and Beitz, see Audard C (n 30) 67.

⁴⁴ Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21) 212-213.

⁴⁵ *ibid* 222.

⁴⁶ Pogge T, *Realizing Rawls* (n 1) 254.

nature of Rawls' theory is also something Pogge has criticised. In arguing the reasons for and against *The Law of Peoples* it will be shown that it is possible for *A Theory of Justice* to apply globally and therefore Rawls' own defence and extension is flawed and unnecessary.

5.1.1.5 Is 'The Law of Peoples' Needed?

Up to now discussion has been critical of the content of *The Law of Peoples* and the theory as disjointed from Rawls' earlier work. Whilst such criticism can reject the law of peoples, it does not provide us with sufficient scope for a global theory of justice. In order to achieve this, attention must be given to a third area of criticism regarding Rawls' law of peoples; the need for it. Rawls argues that his theory of justice must not be applied globally yet many critics suggest that by its very nature, it should be, therefore rendering the flawed, law of peoples, unnecessary. It is this discussion that will now be briefly embarked on to justify not using Rawls' global extension of his own theory but instead to justify use of *A Theory of Justice* on a global scale.

Rawls argues that the law of peoples is necessary because of the increased diversity when applying a theory globally, meaning there will be an increase in the diversity of comprehensive doctrines which will lead to reasonable disagreements. Indeed this diversity is essential for Rawls' domestic-international shift.⁴⁷ There will be many more reasonable disagreements on the global scale as opposed to the domestic, thus Rawls justifies his domestic-international split because there is necessarily an asymmetry of justice; a difference of justice within societies to one between societies. It is the difference between the interests of peoples and individuals that make this asymmetry of justice and requires a necessary split in the

⁴⁷ Tan K-C (n 35) 90.

theories.⁴⁸ Cosmopolitans however, disagree and see no reason why the number of reasonable disagreements would increase globally especially considering the necessary liberalism Rawls imparts on his decent peoples.⁴⁹ Rawls' anti-cosmopolitan view has some support from Audard who argues that trying to apply the liberal principle of justice to all peoples is wrong and gives no moral status to non-liberals, who may still be decent peoples.⁵⁰ In response it can be argued that justice is justice and we should not shy away from our considered judgments for fear of offending people if we believe we are right and fair; "justice is cosmopolitan, not parochial."⁵¹ Pogge also asserts that using two different viewpoints of justice will lead to substantial inequalities which our initial intuition would not accept.

This parochial belief and focus on the difference between the domestic and the international means Rawls fails to create a background principle of justice for the Law of Peoples because he, mistakenly, believes problems that occur in a society (poverty, deprivation, for example) are domestically caused and Rawls ignores global interdependence and the effect it may have in creating such problems.⁵² This is an example of explanatory nationalism, the belief that poverty and deprivation are caused domestically. As many have pointed out before, ignoring global interdependence and external factors is an incomplete and misleading argument.⁵³ Rawls does not completely ignore the need for international help and responds with a very minimal call for assistance but he does argue that when societies do not thrive "the problem is commonly the nature of the public political culture and the religious and philosophical traditions that underlie its institutions. The great social

⁴⁸ Wenar L (n 29) 105.

⁴⁹ Tan K-C (n 35) 90; see also Wenar L (n 29) 100.

⁵⁰ Audard C (n 30) 67.

⁵¹ Pettit P (n 29).

⁵² Rawls J, *The Law of Peoples* (n 3) 108.

⁵³ Beitz CR, *Political Theory and International Relations* (n 1) p. 170; Pogge T, *Realizing Rawls* (n 1); Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21).

evils in poorer societies are likely to be oppressive government and corrupt elites".⁵⁴ These evils in poorer societies and problems with the political culture may well be a truth, but they are not *the* truth. Indeed as Pogge points out "there is a distinct possibility that the domestic factors he [Rawls] cites are themselves significantly shaped and sustained by external factors."⁵⁵ Pogge uses the example of eminent domain powers for those in charge of a country, regardless of how they achieved their power as an example.⁵⁶ Beitz also highlights that the terms of cooperation are set by the wealthy in establishing a coercive relationship making them the more powerful partner.⁵⁷ Thus it seems merely holding that the rich societies have a positive obligation for minimal assistance is not an accurate assessment of the problems encountered in a poorer society, and Pogge differs from Rawls in that he argues for a failure of a negative duty by the rich societies to not cause harm, which they breach by imposing the current global economic order that foreseeably causes avoidable human suffering.⁵⁸

Another reason Rawls is insistent that his theory of justice should not be applied globally⁵⁹ is the Kantian argument against the practicality of a world government.⁶⁰ Pogge responds by firstly pointing out that we can see such divisions of power working in practice as seen in the European Union, so Rawls' reasoning does not

⁵⁴ Rawls J, 'The Law of Peoples' (1993) 20 Critical Inquiry 36, 64.

⁵⁵ Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21) 219.

⁵⁶ The present global institutional order allows for sales of resources and borrowing in the countries name, which can serve to support the powerful and the evils in a society. This also encourages coup attempts by military leaders who know they will gain such power and access to funds even if the country has a well-meaning democratic leader, see Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21) 220.

⁵⁷ Beitz CR, *Political Theory and International Relations* (n 1) 160.

⁵⁸ Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 24) 221; also Pogge T, *Realizing Rawls* (n 1); see also D'Souza C (n 25) 1. Beitz argues slightly differently by stating aid should not be considered as charity, but as redressing distributive injustice. See, Beitz CR, *Political Theory and International Relations* (n 1) 172-173.

⁵⁹ Rawls J, *The Law of Peoples* (n 3) 4, 115-116.

⁶⁰ Which is why Kant compromises and requires well-ordered republican interacting States which enter into a federation of peoples which merely aims to secure the freedom of each State, not gain any overarching power for itself. Kant I, *Perpetual Peace* (n 6) 100-104.

stand up in practice.⁶¹ Secondly, Pogge contends that such a limitation to Rawls' theory of justice, not to be applied globally, would mean therefore that other limitations would necessarily need to be established, such as population size for the society, something Rawls does not consider. Without this knowledge national boundaries have no moral significance and social cooperation would be understood as global, therefore leading to global application of the principles of justice.⁶² And finally it is argued that the infeasibility of a world-government does not itself defeat the potential globalisation of Rawls' theory because it allows many different feasible institutional designs within it.⁶³

It is agreed here that Rawls' reasoning for the difference between his two theories is wanting as the only defence Rawls offers is that the representatives would find no reason to depart from the eight principles proposed. In fact, Pogge finds this reasoning of Rawls not only scant defence, but also false, as he believes the representatives will have reason to consider explanatory nationalism, false. Thus they would agree to design the global institutional arrangements in a way that does not exert "centrifugal force".⁶⁴ Thus Pogge concludes that "the parties in Rawls's international original position would agree to constrain the treaty making of well-ordered societies to rule out a global economic order that would tend to aggravate and reinforce international economic inequalities."⁶⁵

In writing *The Law of Peoples*, it is argued that Rawls recognises the cosmopolitan nature of his theory of justice.⁶⁶ Rawls focuses on his domestic theory's institutional

⁶¹ Pogge T, 'Moral Progress' in Lupor-Foy S (ed), *Problems of International Justice* (Boulder 1988) 285 where he rejects the desirability of a world government in the same form as a domestic State.

⁶² Beitz CR, *Political Theory and International Relations* (n 1) 51.

⁶³ Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21) 208.

⁶⁴ *ibid* 222.

⁶⁵ *ibid* 223.

⁶⁶ Wenar is critical of such an idea and argues that actuarially there can never be a true cosmopolitan theory if we accept that a world government is undesirable and would not work. Therefore any agreements we may ponder in a theory of justice will refer to membership of

assessment and how additional principles of justice that govern international relations might help and compliment his theory. Yet many believe the necessary requirements in Rawls' theory of a closed system that is self-sufficient fits even better within an international theory than a domestic one.⁶⁷ In deciding to globalise Rawls' theory, Pogge suggests Rawls would agree with Kant that just institutions are only required when there is unavoidable interaction. Thus it is argued since there is global interdependence,⁶⁸ and that "all agree there is and [it] will be extensive",⁶⁹ we must look at the conception of justice through adaptation to the real world, and not the closed system societies Rawls suggests. Essentially the argument is to throw out the law of peoples, and adapt *A Theory of Justice* so as to provide a better theory for the realities of the world and the effect of global interdependence.⁷⁰

5.1.2 A Global Theory of Justice

The general advantages seen in applying *A Theory of Justice* globally have been highlighted by Pogge:

Applied globally, it would instruct us to design global political institutions that would secure the basic liberties of human beings as far as possible and to design the global economic

states automatically rescinding its cosmopolitanism. He criticises the theories of Beitz and Pogge for example as not being pure cosmopolitanism as they must refer to people being members of states. However, Pogge and Beitz are not after a pure, idealist cosmopolitan theory, and in much the way that Rawls believes his Law of Peoples can be realised, Beitz and Pogge (among others) have established theories that are in many ways ideal, but also crucially, realist; see Wenar L (n 29).

⁶⁷ Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21) 207; see also Pogge T, *Realizing Rawls* (n 1) 240; see also Barry B, *The Liberal Theory of Justice: A critical examination of the principle doctrines in A Theory of Justice by John Rawls* (Oxford University Press 1973) 128-133.

⁶⁸ Beitz CR, *Political Theory and International Relations* (n 1) 144.

⁶⁹ Pogge T, *Realizing Rawls* (n 1) 241.

⁷⁰ Beitz CR, *Political Theory and International Relations* (n 1); Barry B (n 67); Scanlon TMJ, 'Rawls' Theory of Justice' (1973) 121 *University of Pennsylvania Law Review* 1020; Pogge T, *Realizing Rawls* (n 1); Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21).

order so that fair equality of opportunity is realized worldwide.⁷¹

It is strongly suggested by many⁷² that to consider globalising Rawls' entire conception of justice is not incompatible with the most essential elements of his theory. It is the idea of a global difference principle that is most central for the purposes of this thesis and so to briefly recap; inequalities are only allowed if they ensure the worst off are better off than they otherwise would have been. The parties in the original position will initially desire a principle of equality, however if there are inequalities within the basic structure of society that would make everyone better off, they would logically prefer this structure.⁷³

In the *Law of Peoples* Rawls' argues for a duty of assistance as opposed to a duty of justice as found in *A Theory of Justice*. As Scanlon points out, the duty of justice leads to a much stronger claim than the duty of assistance, so it makes a considerable difference where the boundaries are drawn.⁷⁴ This idea takes further the criticism above that Rawls does not impose limits of his theory of justice but merely states it should not be applied globally. He does not however point out any limits in terms of population or area size to suggest what the envisioned limits might be.⁷⁵ Thus with a duty of justice applying to all those in cooperative enterprises who

⁷¹ Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21) 208.

⁷² Many authors agree that Rawls' theory can and should naturally be applied globally and the more specific global element is the difference principle. Scanlon contrasts Rawls' duty of assistance I have highlighted above with that of a duty of justice, and rightly suggests that a duty of justice will lead to a stronger claim. This is the same as the positive and negative duty argument that Pogge makes about global interdependence and applying justice worldwide. Beitz sees this duty as one of redressing previous distributive injustice that our systems have allowed. For Rawls, the duty of justice arises when people are engaged in a cooperative enterprise, in a closed system with interdependence. See Scanlon TMJ (n 70) 1066; Pogge T, *Realizing Rawls* (n 1) ch. 6; see also Pogge T, *World Poverty and Human Rights* (n 1) ch. 5; Beitz CR, *Political Theory and International Relations* (n 1) 172-173.

⁷³ Rawls J, *A Theory of Justice: Revised Edition* (Oxford University Press 1999) 130-9.

⁷⁴ Scanlon TMJ (n 70) 1066.

⁷⁵ Barry B (n 67) 128-129 Barry also criticises Rawls assumption that the society in the original position already exists with such set limits. Rawls hopes this tactic will dodge the difficult question of defining the community allowing him not to accept a global theory, but with the large difference such boundaries will make it is important to consider them, if indeed there are any.

cannot avoid mutually influencing each other,⁷⁶ where would we draw the line or set the boundaries? The simple argument is that it is clear we could not draw any. There is much interdependence globally and States participate in various forms of relationships with each other,⁷⁷ as well as international institutions which are therefore required to be just. Scanlon highlights, aside from the impact of developed countries setting an unjust global economic order, that;

[C]onsiderations of justice apply at least wherever there is systematic economic interaction; for whenever there is commerce there is an institution in Rawls' sense, *i.e.* a public system of rules defining rights and duties etc. Thus the Difference Principle would apply to the *world* economic system taken as a whole as well as to particular societies within it.⁷⁸

Barry and Beitz make a similar point and see no reason why representatives of countries in an original position would not agree to an international difference principle, or maximin if moving away from principles of justice to the uncertainty of economics.⁷⁹ The same arguments used in *A Theory of Justice* to maximise the worst-off would also apply when the scope of the original position is enlarged to decide a global minimum which would not “depend capriciously upon the good luck of being born in a rich society” or vice versa.⁸⁰ Beitz suggests the difference principle would be global because of the justice of natural resources, which would be considered in the same vein as talents in the domestic original position. It is not just or unjust to have different talents or natural resources, what is unjust is the way institutions allow this difference to make people suffer for factors beyond their

⁷⁶ Scanlon TMJ (n 70) 1066; see also, Pogge T, *Realizing Rawls* (n 1) 241.

⁷⁷ Beitz CR, *Political Theory and International Relations* (n 1) 144.

⁷⁸ Scanlon TMJ (n 70) 1066-7 emphasis added.

⁷⁹ Barry B (n 67) 132-3; Remember that Rawls argues that whilst economics would call the principle of maximising the minimum a maximin principle, this is inappropriate for his difference principle because a maximin is choice under uncertainty. See Rawls J, *A Theory of Justice* (n 73) 65-73.

⁸⁰ Barry B (n 67) 129; see also Beitz CR, *Political Theory and International Relations* (n 1) 151.

control.⁸¹ Pogge agrees with this general expansion, but goes into much more detail and establishes his own edited theory.⁸²

The idea that the richer nations in the world only have a *positive* duty to aid poorer nations, is considered false by Pogge, who also contends that such a duty possesses a much weaker claim than one considered as a matter of justice.⁸³ Pogge argues that every person and State has a negative duty not to unduly harm others and seeks to tackle the assumption of the consensus view that the richer countries in the world are not actively harming the poorer countries and therefore only have a positive duty of aid.⁸⁴ Thus, our negative duty to not unduly harm others is invoked if the poverty and suffering caused in those places is due to, or even aided by, ourselves.⁸⁵ A global difference principle would lead to establishing a minimum standard to be guaranteed⁸⁶ and Pogge points out that nationally these arguments are not controversial but he fails to see the difference globally.

⁸¹ Beitz CR, *Political Theory and International Relations* (n 1) 137-138; Rawls J, *A Theory of Justice* (n 73) 87.

⁸² Rawls and Wenar criticise the idea of a global difference principle because unlike the domestic theory of justice, there will not be a target of wealth; a position beyond which wealth ceases to be of someone's interest and they will not desire gaining anymore. This is not a major concern however, firstly because the cosmopolitans are concerned with individual interests and not a state's interests, therefore this may arise for individuals within those states. But more importantly, I am unconvinced by this idea domestically as well and believe that wealth and desire for more money is a very relative thing that will change over time. The targets will keep moving, and there will always be a worse-off that will want more of what their compatriots, or wealthier nations, have. See Rawls J, *The Law of Peoples* (n 3) 117; Wenar L (n 29) 98-99.

⁸³ Pogge T, *World Poverty and Human Rights* (n 1) 140; see also Scanlon TMJ (n 70) 1066; Beitz CR, *Political Theory and International Relations* (n 1) 172-173.

⁸⁴ Pogge T, *World Poverty and Human Rights* (n 1) 139-140.

⁸⁵ *ibid* 141. Pogge uses the analogy of Nazi Germany to make his point. Whilst many Germans did not actively commit some of the horrific crimes that occurred, they were still involved in the institution by paying taxes, accepting the Nazi laws, attending rallies and even enlisting in the army. Thus they violated their negative duty not to unduly harm others and Pogge uses this analogy to then question if this translates to a global picture.

⁸⁶ Pogge uses John Locke's idea of a pre-institutional state of nature and the requirement to leave enough for others. However this proviso would allow disproportionate appropriation if all people are still better off than they would be in the pre-institutional state of nature. Pogge says that given the situation in the poorest countries in the world today, this is clearly not the case, *ibid* 143-5.

Pogge believes Rawls was right in the first instance and that the parties in the original position should be consistently conceived as representing individuals.⁸⁷ The parties still will not know their place in society or hold any information to warrant risk taking or bias, and as such will still be guided by the desire for social primary goods and will choose, in the same way, a maximin criterion and a difference principle.⁸⁸ So using Rawls' thick veil of ignorance from *A Theory of Justice* to support this idea, Pogge leaves Rawls' argument for the two principles of justice completely intact.⁸⁹ Much like the other cosmopolitan commentators, the two principles are now merely directed at the entire world order as the closed system is no longer an individual society (not defined by Rawls anyway) but the world at large.⁹⁰

One may question why Pogge could not simply desire Rawls' domestic theory of justice to be applied in every State? Pogge contends however that his idea is superior to that possibility because Rawls theory does not guarantee powerful States will not abuse their power in the free bargaining that is allowed. Applying Rawls' theory in each State will still allow and lead to unfair, coercive international interactions and thus create large distributional inequalities.⁹¹ Betiz also considers this possibility and notes that States will enter into various relationships with one another and the more powerful State will be able to threaten the vulnerable State as a break in the relationship will cost them much more.⁹² Pogge also argues that his

⁸⁷ Pogge proposes his own "single unified original position global in scope", which he calls 'G'. Here, individual interests are considered, as opposed to the interests of societies or States, much like Rawls' domestic theory and the parties in G are not constrained by their previous choice in the first original position because there is only one. The use of an individualist approach makes the idea compatible with Rawls' original theory of justice, overcoming one of the main criticisms of Pogge about the Law of Peoples. Pogge T, *Realizing Rawls* (n 1) 247-8, 254, 256. Pogge T, 'Do Rawls's Two Theories Of Justice Fit Together?' (n 21).

⁸⁸ *ibid* 254.

⁸⁹ *ibid* 247.

⁹⁰ Beitz CR, *Political Theory and International Relations* (n 1); Barry B (n 67); Scanlon TMJ (n 70) 1020; Pogge T, *Realizing Rawls* (n 1).

⁹¹ Pogge T, *Realizing Rawls* (n 1) 248.

⁹² Beitz CR, *Political Theory and International Relations* (n 1) 146-147.

theory will lead to effective mechanisms of adjudication and enforcement to help ensure governments would comply.⁹³

5.1.2.1 Objections

The most difficult criticism of applying Rawls globally according to Pogge is that of cultural diversity. Rawls' theory might appeal to us and our culture, heritage and values but it may be inappropriate for the vast cultural diversity and traditions in the rest of the world. Such a possibility is one which cannot be ignored and which we cannot escape.⁹⁴ There will not be a neutral criterion across all values and cultures and it is surely wrong to impose ours upon others.⁹⁵ Therefore it would seem we cannot impose Rawls' rationale of justice globally. However what Pogge suggests is that this does not mean we cannot support the idea of using Rawls' principles of justice globally because they are the conclusion of the rationales of justice, and many different premises, criteria and conceptions of justice can yield the same political judgments and conclusions.⁹⁶ Thus the counter argument must show that there will be no overlapping consensus or even a slight possibility of convergence and agreement upon a criterion of global justice. Pogge's impressive response is that the difficulty is not restricted to the global, which is just one case of diversity in considered judgments, rather that Rawls' conception of justice is based on a small set of accepted values with such flexibility as to accept and incorporate cultural diversity easily.⁹⁷

⁹³ Pogge T, *Realizing Rawls* (n 1) 245-6.

⁹⁴ *ibid* 267; see also Burman E, 'Local, Global or Globalized?: Child Development and International Child Rights Legislation' (1996) 3 *Childhood* 45, 45-46; see also Brown C, 'Universal Human Rights: A critique' (1997) 1 *The International Journal of Human Rights* 41, 41.

⁹⁵ Brown C (n 94).

⁹⁶ Pogge T, *Realizing Rawls* (n 1) 268-9.

⁹⁷ *ibid* 270-1.

Another objection to a globalised theory of justice based on the dominant national focus is because of the belief in explanatory nationalism. Pogge does not exclude this view holding that it can be true and indeed for the most part is,⁹⁸ but believes that such a focus is one-sided and does not present an accurate or fair picture. It is clear there is global interdependence and that we live in an increasingly globalised world. Thus even accepting explanatory nationalism it is argued that in a different global environment, lack of fulfilment of human rights would occur less frequently, but we tend to not ask whether there is such a negative duty for those who shape the global institutions.⁹⁹

The global poor have done nothing to deserve their situation. Indeed many of them are children.¹⁰⁰ Add to this the argument that global factors, institutions and the economic order support the establishment and maintenance of such oppressive regimes, it is easy to see how the negative duty not to unduly harm others is being violated.¹⁰¹ These problems are all permitted through the current international financial markets, the rules of which have been dictated by the richer countries of the world.¹⁰² Thus Pogge, Scanlon and Beitz's arguments applying Rawls globally, requires us to apply a global difference principle. In practice, it will be seen that the institutions that currently exist do not support this idea but instead actively harm poorer nations.

The globalisation of Rawls' theory of justice provides a strong, philosophical, moral underpinning and argument for a child's right to healthcare on an international scale,

⁹⁸ Pogge T, *World Poverty and Human Rights* (n 1) 146.

⁹⁹ *ibid* 147.

¹⁰⁰ *ibid* 150.

¹⁰¹ *ibid* 145-50, where eminent domain powers are discussed as an example. Regardless of how the power was obtained such powers remain. Thus a coup d'état results in a dictator who can lend in the countries name and sell their natural resources, gaining money which can be used to further ensure their power. And if such countries eventually come through such turmoil and have free and fair elections and have a good government with legitimate policies for progress and development, they will struggle because of the debts still held from previous dictatorships.

¹⁰² Beitz CR, *Political Theory and International Relations* (n 1) 147.

so as to better justify calls for strong global enforcement. It is contended here that one of the best ways to achieve this strong enforcement is through the courts, but this must be done appropriately. Thus, drawing on lessons from chapter three, this globalising chapter will now suggest a framework for how a domestic and international court should adjudicate a right to healthcare.

5.2 A Global Framework for the Justiciability of ESC Rights

5.2.1 Reasonableness

The proposed framework here will be an amalgamation, or so called combination approach,¹⁰³ of the test of reasonableness and the enforcement of a minimum core as used in Columbia. There is plenty of literature that argues South Africa provides an excellent example of ESC rights justiciability and the best argument against critics who believe it is impossible for a court to make such decisions in a democracy with a separation of powers doctrine.¹⁰⁴ A test of reasonableness is important because it circumvents criticisms of resource allocation decisions being taken by the court. A test of reasonableness is not a political one of whether the

¹⁰³ Chowdhury J, 'Judicial Adherence to a Minimum Core Approach to Socio-Economic Rights - A Comparative Perspective' (2009) Paper 27 Cornell Law School Inter-University Graduate Student Conference Papers 1; Davis T, 'Towards A Conceptual Framework To Evaluate World Parliament Proposals' in D'Souza A, and D'Souza C, (ed), *World Constitutionalism* (Cambridge Publishing Group 2007) 145, argues that some ideas need to be analysed in their constituent parts so that useful suggestions are kept and to avoid discarding the entire concept simply because another part of the idea is disagreeable.

¹⁰⁴ Bates E, 'The United Kingdom and the International Covenant on Economic, Social and Cultural Rights' in Baderin M, and McCorquodale, R. (ed), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007) 286-287; see also Sachs A, 'The Judicial Enforcement of Socio-Economic Rights: The Grootboom Case' (2003) 56 *Current Legal Problems* 579; see also Pieterse M, 'Coming to terms with Judicial Enforcement of Socio-Economic Rights' (2004) 20 *South African Journal of Human Rights* 383; see also Van Bueren G, 'Including the Excluded: the case for an economic, social and cultural Human Rights Act' (2002) Public Law 456. It will be recalled that UK case law provides similar good examples but South African jurisprudence is very similar and based on the UK's, yet South Africa considers a codified right therefore providing better lessons for international human rights law.

policy is correct; it necessarily allows for reasonable disagreement as well as different systems, such as that seen in Germany and the UK, through the important margin of appreciation.¹⁰⁵ Some suggest that judicial review removes choice between policies,¹⁰⁶ yet this is mistaken as it only removes “the possibility to choose an unreasonable – disproportionate – policy.”¹⁰⁷ In *Soobramoney* the court said “[i]t has not been suggested that these guidelines are unreasonable or that they were not applied fairly and rationally”.¹⁰⁸ Thus the court began to think along the lines of whether the policy the government had in place was reasonable given the circumstances. The court considered that to progressively fulfil the right “the Constitution states in so many words that the state must take reasonable legislative and other measures, within its available resources”.¹⁰⁹ It is clear that reasonableness is the measure that is used by the court and part of this is availability of resources. The court also avoided the temptation to analyse the right to health individually as in Brazil. Albie Sachs was wise to the difficulties such precedent would set arguing that “to have upheld his [Soobramoney’s] claim as against others waiting for treatment, could well have meant in practice that those with the most money could run to court to get help and leave the disadvantaged without treatment.”¹¹⁰ This is exactly the problem Ferraz and others have argued is seen in Brazil.¹¹¹

¹⁰⁵ Kumm M, ‘The Idea of Socratic Contestation and the Right to Justification: The Point of Rights-Based Proportionality Review’ (2010) 4 *Law and Ethics of Human Rights* 141, 168-170; Möller K, ‘From constitutional to human rights: On the moral structure of international human rights’ (2014) 3 *Global Constitutionalism* 373, 383.

¹⁰⁶ Waldron J, ‘The Core of the Case Against Judicial Review’ (2006) *Yale Law Journal* 1346.

¹⁰⁷ Möller K (n 105) 390.

¹⁰⁸ *Soobramoney v. Minister of Health (Kwazulu - Natal)* 1998 (1) SA 765 (CC) para 25.

¹⁰⁹ *ibid* para 43.

¹¹⁰ Sachs A, ‘Social and Economic Rights: Can They Be Made Justiciable?’ (2000) 53 *Southern Methodist University Law Review* 1381, 1386.

¹¹¹ Ferraz OLM, ‘Harming the Poor Through Social Rights Litigation: Lessons from Brazil’ (2011) 89 *Texas Law Review* 1643; Ferraz OLM, ‘The Right to Health in the Courts of Brazil: Worsening Health Inequities?’ (2009) 11 *Health and Human Rights*; see also Prado MM, ‘The Debatable Role of Courts in Brazil’s Health Care System: Does Litigation Harm or Help?’ (2013) 41 *Journal of Law, Medicine and Ethics* 124.

In *Grootboom*, the court elaborated and consolidated its test of reasonableness. The court reaffirmed that the test of reasonableness does not cross into the politics of government policy:

The precise contours and content of the measures to be adopted are primarily a matter for the legislature and the executive. . . . The question would be whether the measures that have been adopted are reasonable. It is necessary to recognise that a wide range of possible measures could be adopted by the state to meet its obligations.¹¹²

Thus clear deference to government and different political ideas can be seen with the court accepting that there will be many different plans and ideas that will fulfil the reasonableness test and which one is the best, is not for the court to decide. The court added that the State has a constitutional obligation beyond legislative measures to directed policies and programmes that themselves must be reasonably implemented.¹¹³ Thus, the court attempted to be more assertive in the implementation and follow up to the orders and measures taken. As was seen earlier however, for *Grootboom* this did not work. This does not mean that the jurisprudence of the court was wrong. The test of reasonableness had been clearly defined and the State's housing plan had been found to be unreasonable, yet no further orders were made, not even as to costs. Despite this minimal decision there has still been a lack of political adherence, which will always be a concern and potential problem; the best a court can do is to establish a respected and consistent jurisprudence as they have "no influence over either the sword or the purse".¹¹⁴

5.2.2 Accountability for Reasonableness

¹¹² *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 41.

¹¹³ *ibid* para 42.

¹¹⁴ Hamilton A, 'The Judiciary will always be least dangerous to the political rights of the Constitution' *The Federalist* No. 78 (New York, June 1788).

This idea of a test of reasonableness finds support from the salient authors discussed in the last chapter. Daniels extends an element of Rawls' theory of justice to establish his "accountability for reasonableness".¹¹⁵ The idea behind this concept, Daniels states, is to establish a fair process within which to set health priorities. Daniels thus tries "to characterize the general conditions such a process must meet if it is to yield outcomes that are perceived as fair and legitimate."¹¹⁶ If these conditions are characterised and met, it will ensure a fair process for decision making, which is the idea of an accountability for reasonableness. In terms of allocating resources to healthcare, it is unknown or uncertain what the correct decision is as Daniels points out, fair-minded people will disagree. Thus if a framework is followed, then the decision is fair and just even if hindsight shows it to be wrong. However it will be argued that the first stage of allocating resources to the right to healthcare will establish a basic minimum and anything different must be part of what Daniels puts forward as the appeals condition which will be returned to below.

I connect Daniels' accountability for reasonableness to the jurisprudence of the South African Court as an example of imperfect procedural justice and a fair decision making process. As mentioned, the court acknowledged that there could be many different policies that are reasonable, but the role of the court was not to decide which reasonable policy is best. Daniels makes a similar point with reference to his accountability for reasonableness stating that reasons for a policy must be publicly available and ones that fair-minded people agree are relevant.¹¹⁷

This was seen, but not explicitly established as part of the test, in the *TAC* case when the court found any argument based on lack of resources would be

¹¹⁵ Daniels N, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008)

¹¹⁷.

¹¹⁶ *ibid.*

¹¹⁷ *ibid.*

unreasonable as *nevirapine* was available to the State for free, thus making resource constraints not relevant to the argument and therefore any argument based on this, unreasonable. Daniels clarifies that policies must be based on reasons that “fair-minded people consider relevant in providing high-quality care to all with limited resources.”¹¹⁸

The idea is to establish a framework for the decision making process at the first instance, within government. If this is adhered to then there would be no need for litigation and a justiciable right to healthcare, although such options should remain available. So the framework for adjudicating the right to healthcare in essence should test whether the government has followed the decision making process in making an appropriate, or reasonable, decision. Daniels puts forward four conditions as integral to this; the publicity condition; the relevance condition; the revision and appeals condition; and the regulative condition.¹¹⁹ For the purposes of the justiciability of ESC rights, it seems that the revision and appeals condition is the part of Daniels theory that can be extended as it demands the opportunity to challenge decisions and, in assessing that challenge, reasonableness will be considered. Part of this consideration will be the publicity and relevance conditions and whether they have been met. Daniels goes into much more detail about these conditions, such as discussing cost-effectiveness and the way to vet relevance of

¹¹⁸ *ibid* 118.

¹¹⁹ *ibid* 118-119. 1) *Publicity Condition*: Decisions regarding both direct and indirect limits to meeting health needs and their rationales must be publicly accessible. 2) *Relevance Condition*: The rationales for limit-setting decisions should aim to provide a *reasonable* explanation of how the organization seeks to provide “value for money” in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a rationale will be “reasonable” if it appeals to evidence, reasons and principles that are accepted as relevant by (“fair-minded”) people who are disposed to finding mutually justifiable terms of cooperation. Where possible, the relevance of reasons should be vetted by stake-holders in these decisions – a constraint easier to implement in public than in private institutions . . . 3) *Revision and Appeals Condition*: There must be mechanisms for challenge and dispute resolution regarding limit-setting decisions, and, more broadly, opportunities for revision and improvement of policies in the light of new evidence or arguments. 4) *Regulative Condition*: There is either voluntary or public regulation of the process to ensure that conditions 1-3 are met.

reasons,¹²⁰ but focuses more on the decision making process and specific appeals by patients. In this instance, Daniels favours an internal system of revision and appeals but does suggest that in general policy appeals with broader elements, the courts may be used. Thus it seems Daniels would fully support a test of reasonableness as seen and used in South Africa.

5.2.3 Addition of the Minimum Core

It has been suggested above, that certain decisions will not need to go through this decision making framework to ensure that whatever decision is made is fair, just and reasonable because they are so fundamental and obvious that fair-minded people cannot disagree. This idea is the amalgamation of the South African test of reasonableness and the Columbian use of the minimum core. The test of reasonableness is necessary to defer to government and accept the difficulties of making certain resource allocation decisions, yet the minimum core concept adds the addendum that this deference only occurs beyond a certain point. It is also suggested that the reasonableness test alone fails to provide meaningful content to ESC rights as it is rather subjective and the minimum core very much adds this specific content.¹²¹ Rather than use two tests however, it is postulated here that simply adding the minimum core to the test of reasonableness can provide the appropriate framework and jurisprudence. It can be simply contended that failure to fulfil the minimum core is unreasonable. This is not a novel proposition, nor is it exclusive to academia. In *Grootboom* the court's focus was on relief for those in desperate need and it was considered unreasonable to not provide for such

¹²⁰ *ibid* 119-130.

¹²¹ Chowdhury J (n 103).

people.¹²² Davis explains how the most vulnerable were also required to be the first group considered, offering a striking resemblance to the idea that not realising a minimum core first and foremost, is unreasonable.¹²³ The court came close therefore to incorporating a minimum core within its reasonableness test, but avoided doing so because of an apparent lack of information.¹²⁴ Yet the court specifically noted that the minimum core could be an aspect in determining reasonableness.¹²⁵

In the later *TAC* case the court stated that if a minimum core approach was used it would itself still be subject to a reasonableness test.¹²⁶ Thus it would not become an automatic and direct demand for everyone. The court is thus saying that if the minimum core were to be used, it would be used in the context of reasonableness in that it would be admissible because it is considered unreasonable to not provide a minimum core to the right. This proposal, whilst not adopted by the court, is precisely the framework that should be adopted to ensure appropriate deference with a reasonableness question, yet demanding adherence with the specificity a minimum core can provide.

¹²² *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 66 emphasis added.

¹²³ Davis DM, 'Adjudicating the Socio-Economic Rights in the South African Constitution: Towards 'Deference Lite'?' (2006) 22 South African Journal on Human Rights 301, 306, emphasis added and footnotes omitted; see also *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 44.

¹²⁴ *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) para 33. "[T]he real question in terms of our Constitution is whether the measures taken by the state to realise the right . . . are reasonable. There may be cases where it may be possible and appropriate to have regard to the content of a minimum core obligation to determine whether the measures taken by the state are reasonable. However, even if it were appropriate to do so, it could not be done unless sufficient information is placed before a court to enable it to determine the minimum core in any given context. In this case, we do not have sufficient information to determine what would comprise the minimum core obligation in the context of our Constitution."

¹²⁵ Grant E, 'Enforcing Social and Economic Rights: The Right to Adequate Housing in South Africa' (2007) 15 African Journal of International and Comparative Law 1, 22.

¹²⁶ *Minister of Health v Treatment Action Campaign* (2002) 5 SA 721 (CC) para 34.

Exactly how much specificity there should be is difficult but the Colombian Court avoided such problems by not adding details of the protected health services but ordering the government to determine what services were to be part of the minimum core.¹²⁷ It also ordered that these services were to be immediately enforceable and beyond resource constraints as part of their 'structural approach'. The content of the minimum core had to be in line with the country's international obligations under the ICESCR and more specifically General Comment 14. This is of course something to add to the reasonableness framework. The requirements of *availability*, *accessibility*, *acceptability* and *quality* under General Comment 14 should be considered as part of the minimum core.¹²⁸ It would be unreasonable to have a basic minimum guarantee to respect, protect and fulfil a certain health service beyond resource constraints, because it was so vitally important, but not ensure it is accessible to all and universal for example. Such international obligations should be ensured as a bare minimum, along with fulfilling the minimums put forward by the WHO, such as those seen in chapter one for example. If those minimums are considered and constitute part of a country's minimum core, along with the requirements under General Comment 14, in essence a 'minimum' minimum core can be established. States can add other healthcare services to their minimum core if they choose, which arguably developed regions should do, but even for the poorest nations there is a 'minimum' minimum core that they must look to fulfil. This idea is similar to Bilchitz arguing for two obligations that arise from a single right to health, the first of which is a minimum that is beyond resource constraints. This minimum is so basic and focuses on survival needs as to be compared to the idea of 'minimum' minimum

¹²⁷ Yamin AE, and Parra-Vera O, 'How do courts set health policy? The case of the Colombian Constitutional Court.' (2009) 6 PLOS Medicine e1000032.

¹²⁸ Committee on Economic, Social and Cultural Rights *General Comment No. 14 - the Right to the Highest Attainable Standard of Health* (2000) 12.

core. These “minimum subsistence rights”¹²⁹ are also seen in the Limburg Principles as the immediate obligations beyond resource constraints. After this, progressive realisation requires incremental improvement to what resources allow, as Bilchitz explains with regards to the two obligations that arise:¹³⁰

[T]he first is to realise a certain minimum level of provision without delay, and the second is to improve the level of provision beyond this lower threshold by taking reasonable measures to meet a higher threshold that must be attained if the right is to be fully realised. Such an approach thus recognises that there is only one right, but such a right gives rise to two different obligations upon the state.¹³¹

5.2.4 Presumption of Unreasonableness

Using the minimum core in this way also has advantages for enforcing the rights in the courts because of what Liebenberg and Young have suggested as a shifting of the onus of proof.¹³² Liebenberg suggests a “presumption of unreasonableness”¹³³ when it can be shown that basic goods are not being provided to those in need. She argues this idea does not demand one inflexible policy but does require the use of the minimum core concept levels of provision; “this approach does not require the setting of inflexible minimum standards of delivery. . . . However, it does require placing a strong burden of justification on the state in relation to the absence of basic levels of provision for groups living in poverty.”¹³⁴ Liebenberg agrees with the South African Constitutional Court in *Grootboom* that different circumstances for

¹²⁹ Committee on Economic, Social and Cultural Rights, *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights* (1987) 25.

¹³⁰ Grant E (n 125) 23.

¹³¹ Bilchitz D, 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence' (2003) 19 South African Journal of Human Rights 25, 11.

¹³² Liebenberg S, 'The Value of Human Dignity in Interpreting Socio-Economic Rights' (n 157) 22-26; see also Young KG, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 The Yale Law Journal of International Law 113, 159.

¹³³ Liebenberg S (n 132) 23.

¹³⁴ *ibid* 23-24.

different people will mean different needs and an inflexible minimum core would be insensitive to that.¹³⁵ In essence different policies may achieve different needed outcomes yet she argues the presumption of unreasonableness should be established when basic services that are required to sustain a basic level of functioning are not provided.¹³⁶ This is similar to what the minimum core seeks to ensure for all people. If a minimum core can be established that ensures and protects the “basic level of functioning”¹³⁷ for all, it would create the presumption of unreasonableness if not being guaranteed, unless, according to Liebenberg there was evidence that this minimum core was not in that individual’s interests. The presumption of unreasonableness fits with the accountability for reasonableness proposed that requires fulfilment of the minimum core as a first step. If this is not achieved, it can be presumed unreasonable, and the onus of proof shifts to the government failing to provide the minimum core, which in turn requires strong justification for its policies and resource constraints. Thus Liebenberg’s strength is the presumption of unreasonableness. Her weakness is failing to acknowledge that the minimum core is an important part of establishing unreasonableness, as Young has suggested.¹³⁸ Using Liebenberg’s argument, Young points out how important the minimum core can be to reversing the onus of proof onto the State that it has taken reasonable measures and any limitations are justifiable.¹³⁹

Thus once it is established that the minimum core is not being fulfilled, it falls on the State and the government to prove it has legitimate resource constraints. This presumption of unreasonableness then becomes part of a test of reasonableness as it can be argued whether the government’s failure to provide the minimum core is

¹³⁵ *ibid* 24; see also *The Government of the Republic of South Africa and Others v Grootboom and Others* (CCT 11/00), [2000] No. ZACC 19, 2001 (1) SA 46 (CC) paras 32-33.

¹³⁶ Liebenberg S (n 132) 23.

¹³⁷ *ibid*.

¹³⁸ Young KG (n 132) 159.

¹³⁹ *ibid*, referencing Constitution of the Republic of South Africa (1996), ss 26(2) and 27(2); Liebenberg S (n 132) 26-29.

reasonable because of scarcity of resources, but the onus of proof and requirement of strong justification shifts onto the government and not the litigants. So we have a minimum core as the first requirement of reasonableness and a presumption of unreasonableness when this is not being fulfilled. As has also been seen, part of this is proving that the State has tried to attain any needed international assistance in order to fulfil the minimum core. If it can be shown that it is the developed countries that are failing their obligations, clearly the governments in the poorer nations will not be violating the right. There are some reservations about a court requiring governments to seek international assistance because often loans come with conditions attached and can actually be detrimental to the development of a nation.¹⁴⁰ In such a situation it would be inappropriate for the courts to be making such calls. However, these reservations are because of the conditions placed on such international aid. If these were removed or replaced with a much better and fairer system of global economic distribution, then these reservations would surely cease. This is an issue to which I shall return in chapter six when discussing the global economic order.

5.2.5 Reasonableness and Minimum Core: Separate Entities or Irreversibly Intertwined?

Despite his arguments of a basic minimum as a first obligation of the right to health, Bilchitz contends that the minimum core and test of reasonableness are separate entities that cannot be used within the same test. He argues the:

The minimum core does not gloss the notion of reasonableness; rather, reasonableness is assessed in terms of whether a government has complied with its minimum core obligations in terms of the right. The idea of a minimum core comes from an analysis of the obligations

¹⁴⁰ Chowdhury J (n 103).

imposed by the right and a consideration of the notion of progressive realisation. This is a separate enquiry to that involved in determining the reasonableness of the measures adopted by the government.¹⁴¹

The argument here could be that minimum core adds specific content, and its purpose is a debate on what that content should be. Reasonableness however is a discussion where actual content of healthcare and what is being provided is not assessed. However it seems unconvincing to suggest they are separate enquiries given the admission that reasonableness is assessed in terms of the minimum core. If they are assessed in terms of each other, it remains unclear how they can be separate. Without the fulfilment of the minimum core, there should at least be a 'presumption of unreasonableness'. The two enquiries occur simultaneously. It is true that assessing the fulfilment of the minimum core is an enquiry that helps establish reasonableness, whereas reasonableness is not an enquiry that changes the outcome of whether the minimum core is being fulfilled. However, this does not mean they are entirely separate enquiries as they are part of a larger test of reasonableness, for which assessing fulfilment of the minimum core is the first stage. Failure to fulfil the minimum core can still be reasonable, and fulfilling the minimum core can still lead to a conclusion that the government's policies beyond this fulfilment are unreasonable. The enquiries of minimum core fulfilment and reasonableness cannot be separate, as the minimum core should be part of the reasonableness assessment. Indeed they are irreversibly intertwined as they are both assessed within the scope of each other; assessing reasonableness begins with fulfilment of the minimum core; whereas any lack of fulfilment of the minimum core establishes a presumption of unreasonableness and thus a strong justification required from the government.

¹⁴¹ Bilchitz D (n 131) 12.

Bilchitz argues that the courts should use the minimum core approach and that the basic 'minimum' minimum core will be beyond resource constraints and must occur without delay.¹⁴² He argues it is "unclear why the Court is so set on distancing itself from the minimum core approach [which] . . . suggests that there are degrees of fulfilment of a right and that a certain minimum level of fulfilment takes priority over a more extensive realisation of the right."¹⁴³ Establishing this 'minimum' minimum core can be a good first step for each country. The amount of money needed to ensure this 'minimum' minimum core can then be estimated and can help inform whether a State is being reasonable if it is not realising this right. It can also better inform where international cooperation is needed; direct government finances and infrastructure, which leads to more sustainable healthcare solutions; and can also lead to a required minimum spending by all States on healthcare, which can be calculated with reference to a minimum percentage GDP incorporated into international obligations. Such ideas will be looked at further in chapter six.

The establishment of this framework leads to the idea that this test of reasonableness which incorporates a minimum core should be used in all courts when adjudicating ESC rights; national, regional and international. While courts are not a panacea., "[t]his does not mean . . . that the courts cannot make a significant contribution to the enforcement of the child's right to health."¹⁴⁴ The courts can be a powerful tool in enforcing the right to healthcare but even if there were many courts across the world willing to adjudicate ESC rights responsibly in the way proposed, there is no guarantee of implementation. Avoiding this possibility is part of why it is important to follow a respected jurisprudence as well as apply that similar

¹⁴² *ibid* 11.

¹⁴³ *ibid* 13.

¹⁴⁴ Nolan A, 'The Child's Right to Health and the Courts' in Harrington J, and Stuttaford M, (ed), *Global Health and Human Rights: Legal and philosophical perspectives* (Routledge 2010) 146, 154; see also Forman L, 'Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy' (2005) 33 *The Journal of Law, Medicine and Ethics* 711.

adjudication internationally, but lawsuits may also not be the best means of asserting children's rights.¹⁴⁵

5.3 Concluding Remarks

The *Law of Peoples* was presented as an extension of Rawls' domestic theory of justice, but crucially Rawls saw the need for a different exercise because for him, justice between societies is different from justice within societies. Here, Rawls' global theory was briefly presented and critiqued in order to justify not using the authors own extension of his domestic theory. It has been shown how the domestic theory of justice is to be applied globally, especially the difference principle, which for the purposes of this thesis is important for realising a child's right to healthcare in practice with the necessary redistribution of resources as a matter of global justice.

Equally important to realising global justice is the enforcement and implementation of rights, otherwise the philosophical arguments serve to convince, but are meaningless in practice. This is why the role of the courts was discussed in chapter three and then again above. If rights, such as a child's right to healthcare, are to be enforced and meaningful, then their forceful implementation through the courts should be seen as perhaps the best guarantor. This jurisprudence and adjudication must, however, be done appropriately and in the correct way so as to avoid judicial over-stepping, and equally must be thought of as global, especially if the consideration is the judicial enforcement of international human rights. Thus, the framework above draws on comparative lessons around the world as the best examples for judicial decisions about codified economic, social and cultural rights. It

¹⁴⁵ Leary VA, 'The Right to Health in International Human Rights Law' (1994) 1 Health and Human Rights 25, 39.

has been argued that from these lessons, any court, domestic or international, should use a test of reasonableness when deciding on a government's policy without losing sight of a basic minimum standard. There should be a presumption of unreasonableness when it can be shown that the minimum core of a right is not being realised, which therefore shifts the onus of proof onto the government to prove its resource constraints. If this framework was applied globally it would ensure a substantial change in the way such rights are viewed and enforced. The more precise changes that are required to enhance a child's right to healthcare are now discussed in the concluding chapter, including changes to the global economy and redistribution of money, and the possibility of a World Court of Human Rights, which would, of course, be expected to follow the recommended jurisprudence and framework above.

Chapter Six

Time to Change

In this penultimate chapter, the thesis pulls together the conclusions made from the variety of disciplines discussed so far and take them further, adding greater detail to the ideas proposed. It has been shown that there is an inequity in children's access to healthcare services and that provision of such services are indeed a matter of justice. Any State that can be considered just, therefore must provide a basic minimum of healthcare services to children. It has also been shown that this is a global problem, not one that can be restricted within the confines of random, post original position, borders. Therefore, the problems encountered require global solutions and application of a global difference principle. Equally important, as demonstrated in the last chapter, is a global legal response. These multiple conclusions will be taken further in this chapter; combined, and enlarged to demonstrate the pragmatic possibilities, and better illustrate the overall conclusion to this thesis.

Firstly this chapter will address the issues raised around minimal healthcare provision being a global problem that requires a global response, with a redistribution of global resources. It will establish the philosophical foundations for this argument before demonstrating that such a bold suggestion does not have to be empty, impractical words. After showing the economic possibilities to achieve global healthcare provision with a minimal redistribution of resources, it will also be argued that there is a legal responsibility on the world's financial institutions. Section 6.1 therefore answers the philosophical, economic, and legal questions around redistributing global resources to ensure a child's access to a minimum core of healthcare. The legal position is taken further in the next section where the young

area of global constitutionalism is considered. Here, international law's comparison to a superior world constitution as codified law is discussed, which is why the framework of the previous chapter used examples for the way a written right to healthcare had been enforced and adjudicated through the courts. If international law is akin to a written constitution, it should be enforced in a similar way to that suggested so as to avoid the pitfalls of the less successful implementers of rights. This then takes discussion into proposals for more active enforcement and the flagship recommendation of a World Court of Human Rights. This is recommended among many other changes that would help make the United Nations a powerful human rights implementer; a change long overdue to avoid its demise into insignificance akin to a second League of Nations.

6.1 Can We Afford Global Health Justice?

The bleak picture of healthcare around the world was highlighted in chapter one as well as the stark contrast between per capita spending on healthcare in some of the wealthiest countries in the world and some of the poorest. The effect this has on health is shown by reminding ourselves that the infant mortality rates of South Africa and India were 41 and 48 (per 1,000 live births) respectively in 2010, compared to just 7 and 3 for the USA and Germany. As was also discussed in chapter one, this is hardly surprising given that India spends just US\$141 (PPP) per capita on total health expenditure compared to Germany's US\$4,495.¹ Yet it should also be reiterated that the USA spends US\$8,508 per capita for slightly worse health

¹ Organization for Economic Co-operation and Development *Health at a Glance 2013: OECD Indicators*, (2013) 155.

outcomes than other similar countries such as the UK and Germany, showing that money needs to be better directed at creating a fundamental and universal healthcare system.²

In the first section of this chapter, ways to change this will be explored, and more specifically, ways to ensure that the poorest nations have the means to ensure the minimum core content of the right to health. As is seen with the United States however, merely spending more money does not automatically lead to better healthcare,³ yet ensuring the minimum core seems an appropriate place to start if funds can be directed for such a purpose. Thus in this section the focus is on using the idea of globalising Rawls discussed in the last chapter and ensuring a global difference principle as a moral foundation and justification for change. Discussion will then focus on the more practical problems of redistributing global resources to counter suggestions that it may not be possible or anywhere near enough for ensuring a minimum of children's healthcare.

6.1.1 Philosophical Foundations for Change in the Global Economic Order

Whilst Pogge's work was used to globalise Rawls theory of justice, he has also taken this further to suggest how this might actually be achieved by making arguments to implement a global difference principle. His particular idea of a Global Resources Dividend (GRD) is designed to help with the broader area of poverty in general.⁴ The GRD is based on the natural resources found within the territory of a

² *ibid*; see also Davis K, Stremikis K, Squires D, and Schoen C, *Mirror, Mirror On The Wall: How the Performance of the U.S. Health Care System Compares Internationally* (The Commonwealth Fund, 2014) 11.

³ See Section 1.3.3.

⁴ Pogge T, *World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms* (Second edn, Polity Press 2008) 202-221; see also Pogge T, 'Eradicating Systemic Poverty:

State and Pogge suggests that governments should make payments for use of the planet's resources into this dividend.⁵ This GRD fund is then to be used to ensure all human beings have a basic minimum standard of living. Repeating his arguments that the affluent countries of the world impose the current global order that, at the very least, contributes to severe poverty, Pogge argues that those who "make more extensive use of our planet's resources should compensate those who, involuntarily, use very little."⁶ This is the basis of his argument for redistribution of global resources. Stewart and Daws similarly argue that as the distribution of capital flows among countries is so uneven, it demands action at the global level in order to correct this.⁷

The changes proposed by Pogge do not impact upon eminent domain as the decision to use the resources is still that of governments, but those that do choose to, by buying or selling, contribute to the GRD which can be targeted towards reducing poverty. Pogge acknowledges that practical problems will emerge, especially if either the US or EU cannot be persuaded to participate and help ensure payments,⁸ but believes that once this barrier is overcome, sanctions such as import and export taxes,⁹ will ensure compliance from all States to create a GRD with vast resources that can be appropriately spent. The underlying moral idea why Pogge favours the creation of such a fund or dividend is because it avoids the usual notions of charity and dependence and instead "incorporates into our global

brief for a global resources dividend' (2001) 2 *Journal of Human Development* 59; Pogge T, 'An Egalitarian Law of Peoples' (1994) 23 *Philosophy & Public Affairs* 195.

⁵ Pogge T, *World Poverty and Human Rights* (n 4) 202; a dividend is used because Pogge argues the global poor also own a stake in limited natural resources.

⁶ *ibid* 210.

⁷ Stewart F, and Daws S, 'An Economic and Social Security Council at the United Nations' (2001) Queen Elizabeth House Working Paper Series - QEHWPS68.

⁸ Pogge T, *World Poverty and Human Rights* (n 4) 217.

⁹ *ibid* 214.

institutional order the moral claim of the poor to partake in the benefits from the use of planetary resources.”¹⁰

This is Pogge’s basic idea to improve global economic justice and the GRD is designed to show that there are alternatives to the way the economic order is structured.¹¹ Pogge finds it inconceivable to think that with such global interdependence the rich countries are not involved in, influence, or contribute to, the abject poverty across the world. He also finds it equally incredulous that the current global economic order may be the best one possible to conceive, rendering the position of the worst off as best off as possible, as demanded by a just world applying a global difference principle.¹² Pogge is not the only person who has taken up such a challenge or highlighted the connection that globalisation establishes. Stewart and Daws also suggest that “[g]lobal institutions are essential to ensure that the *international implications of national action* are taken into account.”¹³

They propose the establishment of a Social and Economic Security Council.¹⁴ They put forward many reasons for this idea, the most convincing of which is because the current UN Economic and Social Council is widely accepted to be weak and largely ineffective.¹⁵ Thus when it comes to implementing economic and social rights, such as the right to healthcare, the need for change is at least relatively unanimous. Stewart and Daws regret the lack of world governance of agreed social and economic rights and point out that the enforcement mechanisms that are effective are dominated by powerful Western economies. Stewart and Daws argue that one of the reasons the economic and social council is so ineffective, is because of the

¹⁰ *ibid* 213.

¹¹ *ibid* 203.

¹² *ibid* 220-1.

¹³ Stewart F, and Daws S (n 7) emphasis added.

¹⁴ *ibid*.

¹⁵ Arnold T, *Reforming the UN: Its Economic Role* (Royal Institute of International Affairs, 1995) 26; Rosenthal G, 'Economic and Social Council' in Weiss TG, and Daws S, (ed), *The Oxford Handbook on the United Nations* (Oxford University Press 2007) 141.

voting majority of developing countries and so developed countries, those with the resources to implement decisions, refuse to give the council any power. Certainly the most economically influential institutions are the World Bank and the International Monetary Fund (IMF). In theory, these 'Bretton Woods'¹⁶ institutions are under the purview of the United Nations, however, in practice, these authors suggest that this has not occurred at any point.¹⁷ With the method of weighted voting in both the IMF and the World Bank, it is the US and Western Europe that in essence decides the policies of these institutions, a dominance which was controversial at the outset,¹⁸ and a state of affairs which further supports Pogge's argument that the global economic order is decided by a few rich countries.¹⁹ The World Bank and the IMF have become separate entities from the UN despite the theory that they are part of the same system. Indeed, the IMF website actually states that it is a specialised agency of the United Nations, but it has its own, separate charter, governing structure, and finances.²⁰ The Western-centric power of the World Bank and the IMF has made them powerful in economic terms however, so arguments in defence of where their power comes from focuses on the effectiveness of these institutions.²¹ In their argument for an Economic and Social Security Council, Stewart and Daws propose accepting the voting majority of the

¹⁶ Darrow M, *Between Light and Shadow: The World Bank, The International Monetary Fund and International Human Rights Law* (Studies in International Law, Hart Publishing 2003).

¹⁷ Stewart F, and Daws S (n 7).

¹⁸ Darrow M, *Between Light and Shadow* (n 16).

¹⁹ In the IMF each member is assigned a quota. Each member has a basic stock of 250 votes plus one for every part of the quota which is determined by economic data such as GNP and reserves. The USA held almost 18.5% of the vote in 2001. For the World Bank, it is necessary to be a member of the IMF first, and then the members buy shares in the Bank with US\$100,000. The distribution of these shares determines voting rights, starting with 250 similarly to the IMF and then adding one vote per share. Just under 50% of the vote is held by 7 countries as a result, the US, UK, France, Germany, Italy, Canada, and Japan. See Stewart F, and Daws S (n 7). At present, despite new rules to increase the voting power of so-called BRICs countries (India, Brazil, Russia and China) The US, Japan, Germany, France and the UK collectively control 37.37% of the IMF vote.

²⁰ <<http://www.imf.org/external/about/overview.htm>>last viewed 05/03/2015; Uriz GH, 'To Lend or Not To Lend: Oil, Human Rights, and the World Bank's Internal Contradictions' (2001) 14 Harvard Human Rights Journal 197, 202.

²¹ See Stewart F, and Daws S (n 7).

world's most powerful countries, yet unlike the current UN Security Council, refusing to allow them a veto. A special majority of two-thirds should however be required to reach decisions.²² This Economic and Social Security Council would, as part of its establishment, be given authority over the World Bank and the IMF to enable it to meet with and direct those institutions so as to better redistribute finances to securing socioeconomic rights.

These ideas of an Economic and Social Security Council and especially the GRD, have been termed a 'philanthrotax' by Brassington in his moral discussion of such forced philanthropy.²³ Using Harry Frankfurt's earlier arguments,²⁴ Brassington argues the moral acceptability of such a 'philanthrotax' arises because as decent people we would not want to violate the demands of morality.²⁵ The 'philanthrotax' may go against the notion that people and States should be able to choose how to spend their money, but if the ethics and moral thought establish that the redistribution is necessary, and if we assume that decent people and States will want to act in an appropriate way and not violate the demands of morality, then creating a 'philanthrotax' changes nothing and does not add controversy.²⁶ It is not, therefore, morally problematic to be told you must do something you were going to do anyway, and if States acted in a decent way as set out, they would redistribute such wealth anyway. According to this view, a GRD or 'philanthrotax' adds nothing, except potentially greater efficiency. Whilst this is an interesting idea, it fails to provide the detail of where the necessary resources would come from, what is

²² *ibid.* The proposal is for a council of 20-25 members, as anything smaller and the power is too isolated, and anything bigger and the council becomes ineffective. 10 permanent members will come from the economically strongest countries, according to GNP. The other 10 will be voted in by the UN General Assembly and will come from all other regions in the world.

²³ Brassington I, *Public Health and Globalisation: Why a National Health Service Is Morally Indefensible* (Societas, Imprint Academic 2007) 55.

²⁴ Frankfurt HG, 'Alternate Possibilities and Moral Responsibility' (1969) 66 *The Journal of Philosophy* 829.

²⁵ Brassington I (n 23) 55.

²⁶ *ibid.*

needed, and how to attain them if State consent is withheld. This is one of the fundamental problems of idealism, the lack of a practical solution which is the very challenge Norman Daniels left to others.

It will be recalled from chapter four that after accepting Norman Daniels' extension of Rawls' theory to include a right to minimal healthcare provision by the State as a matter of justice, linked to the obligation to ensure fair equality of opportunity, Daniels' challenge to others was to find an appropriate, practical solution between cosmopolitanism and statism not leaning too heavily on one extreme or the other. "This intermediary ground consists of relatively recently formed and evolving international agencies, institutions, and rule-making bodies."²⁷ Both suggestions above would fit within this middle ground and whilst Pogge does make some suggestions where the funds for the proposed GRD would come from, it still lacks the specificity to be considered a serious economic proposal. However, there are others who have made suggestions that are very similar to Pogge's GRD, with much greater economic specificity.

6.1.2 Practical Ideas for Change in the Global Economic Order

Such a specific response has come from Ooms and Hammonds when they call for a Global Health Fund.²⁸ In actual fact, the ideas of Pogge and Ooms and Hammonds fit together exceptionally well, and they are not alone in suggesting that in order to realise a minimum core of the right to healthcare, the resource limitations of many

²⁷ Daniels N, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008) 346.

²⁸ Ooms G, and Hammonds R, 'Taking up Daniel's challenge: The case for global health justice' (2010) 12 *Health and Human Rights* 29.

countries requires a change in the global distribution of resources.²⁹ Using an economic measurement known as the Gini coefficient, Ooms and Hammonds firstly show that wealth inequalities across the world have become much worse in the last twenty years.³⁰ This is predicted by an economic principle called the Matthew effect,³¹ which Ooms and Hammonds use to highlight the injustice such increasing inequalities represent, thus agreeing with Pogge about the violation of a negative duty not to harm and the “critical importance of correcting the obvious harm that is being done by rich countries”.³² Ooms and Hammonds proceed to propose ways to assuage this harm, deciding on a similar solution to the Pogge’s GRD in responding to the idea of a global difference principle. If we accept the free market and a global difference principle, increasing inequalities are not by themselves unjust. However, the difference principle requires such inequalities ensure the minimum standard is better than it otherwise would be, and it seems safe to argue that this is not the case. Ooms and Hammonds argue for a secondary redistribution of wealth at the global level as a way of adjusting the free market to address this problem³³ and then proceed to explain exactly how this could be done.

Their idea begins with securing the minimum core of the right health to all people in every country, which, even as a basic package of health services, is not being achieved. This concept was further discussed in chapter one and will not be repeated here, but a WHO bulletin has estimated that securing the essential

²⁹ Craven M, 'The Violence of Dispossession: Extra-Territoriality and Economic, Social, and Cultural Rights' in Baderin M, and McCorquodale, R. (ed), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007) 82.

³⁰ Ooms G, and Hammonds R (n 28) 31.

³¹ This term is coined by Robert Merton using a verse from the Gospel of Matthew which says; “For to all those who have, more will be given, and they will have an abundance; but from those who have nothing, even what they have will be taken away”. The idea is that prominent scientists are recognised much more for their work than lesser known scientists even if they contribute the same or more so to science. The idea is applied to countries participating in the free market, accounting for the increase in inequalities as it explains that the rich economies gain more investment and achieve more wealth, whilst the poor countries tend to suffer the effects.

³² Ooms G, and Hammonds R (n 28) 31.

³³ *ibid* 32.

services envisaged by the minimum core should cost approximately US\$40 per person per year.³⁴ The kind of international assistance Ooms and Hammonds then recommend is following in the footsteps of the relatively successful Global Fund to fight AIDS, Tuberculosis and Malaria, but instead proposes a Global Fund for Health with a broader mandate for all health related issues. The Global Fund has been an enabler despite no formal burden sharing among donor countries, however it can be submitted that any form of global institution to ensure funds to those countries that need them, must be formal and universal, in this way similar to Pogge's GRD. Such a fund should be subordinate to the United Nations, with the power of sanctions, and can direct money specifically with a view to assisting health interventions.

It is pointed out by Ooms and Hammonds that many of the poorest countries in the world cannot afford even this basic minimum on their own, even if past pledges by the African States are fulfilled.³⁵ Estimating, although admittedly being very optimistic, Ooms and Hammonds believe that it is possible for low-income countries to achieve 20% of its GDP as government revenue,³⁶ and they therefore proceed with an estimate that, to the maximum possible, some of the poorest countries in the world could spend 3% of their GDP on healthcare.³⁷ With this estimate they proceed with an analysis of 59 of the poorest countries in the world where 3% of GDP would not equate to US\$40 per person per year. For example, if 3% of GDP per capita for a country equated to US\$30 per person per year then the total deficit for the country

³⁴ Carrin G, Evans, D., and Xu, K., 'Designing health financing policy towards universal coverage' (2007) 85 Bulletin of the World Health Organization 652; actually they state a requirement of US\$40-45 but base this on a report from 2001 which suggested US\$30-40; see Commission on Macroeconomics and Health, 'Macroeconomics and Health: Investing in Health for Economic Development', (Geneva: WHO, 2001) p. 16; US\$40 appears to be a regular figure to use and so can provide an appropriate estimate; see also Ooms G, and Hammonds R (n 28) 35.

³⁵ Organisation of African Unity *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases* (2001) 26; In 2001 the countries of the OAS pledged to allocate a minimum of 15% of their annual budget to improving the health sector in their respective countries; see also Ooms G, and Hammonds R (n 28) 36.

³⁶ Ooms G, and Hammonds R (n 28) 36.

³⁷ This is 15% from the declaration of the possible 20% GDP.

to be able to afford a minimum core of the right to health is US\$10 multiplied by the population.³⁸ Proceeding along these lines, and multiplying the deficit in each of the 59 countries by the population, Ooms and Hammonds estimated that the total global deficit is approximately US\$50 billion in 2012.³⁹ This is based on the minimum to ensure the most basic essential health interventions, US\$40, however more in depth coverage for all children in the 75 countries with the worst infant mortality rates also creates a similar figure.⁴⁰

The 2005 World Health Report by the WHO estimated that scaling up child health interventions to ensure full coverage in those 75 countries would require additional spending of US\$52.4 billion over 10 years.⁴¹ This additional funding is what is required to ensure full coverage to all children for some of the world's most vital vaccines, as well as treatment for many preventable diseases that cause so many child deaths including diarrhoea, malaria, pneumonia and HIV.⁴² It is the scaling up of coverage of these treatments that the US\$52.4 billion could be used for. Statistics differ slightly but cost estimations tend to be quite similar. The US\$52.4 billion is to be accumulated over ten years, as proposed by the report, which would mean requiring approximately an additional US\$5.24 billion to current funds each year.⁴³

³⁸ India is one country which was included with the GDP per capita of approximately US\$760 in 2005-6. 3% of this equates to US\$22.80 per person per year, thus leading to a US\$17.20 deficit which did mean a deficit of US\$19.8 billion. The OCED data used in chapter one however shows that India spends US\$141 per capita on health, yet this is almost all private funding and very little government spending on free basic health programmes. It is also important to note that the data used is before the meteoric rise of India's economy whose per capita GDP has increased nearly US\$1,000 in nine years. As such, there is no longer a deficit in India with 3% GDP per capita now standing at US\$48.9. This is based on World Bank data of 2014 and India's GDP per capita of US\$1,630.8.

³⁹ Ooms G, and Hammonds R (n 28) 38-9.

⁴⁰ World Health Organization *The World Health Report 2005: Making Every Mother and Child Count* (Geneva, 2005).

⁴¹ *ibid* 116-117; see also Mason E, 'Child survival: time to match commitments with action' (2005) 365 *The Lancet* 1286, 1287; see also Tobin J, *The Right to Health in International Law* (Oxford University Press 2011) 261.

⁴² World Health Organization *The World Health Report 2005: Making Every Mother and Child Count* (Geneva, 2005) 115.

⁴³ However the WHO report talks of scaling up the funding each year from US\$2.2 billion to begin with, ending with US\$7.8 billion ten years later. *ibid* 116.

Another article in *The Lancet* focusing on 23 specific health interventions, mostly preventive care, in 42 countries in the world which were accountable for 90% of child deaths in 2000, returned a similar cost estimation of requiring an additional US\$5.1 billion each year.⁴⁴ The focus was on achieving the millennium development goals for child mortality in these countries and ensuring universality in preventive care such as vaccinations. One of the largest increases in funds required was an extra US\$1 billion to ensure full coverage of the *Hib* vaccine. In total all the 23 interventions were expected to save 6 million lives per year for the additional running cost of just US\$5.1 billion. The 75 countries considered in the WHO report account for 95% of child deaths, covering a population of 4.6 billion in 2005, and 496 million children.⁴⁵ The differences between *The Lancet* article and the WHO report may be due to the fact that some of the countries beyond the 42 used in the article will require very limited scaling up or additional funds in order to achieve universal coverage of necessary interventions. Also, the WHO report does not consider the reduction of treatment costs that will occur if such preventive measures are universally applied, which *The Lancet* article tries to do, estimating a reduction in curative costs of at least 60%.⁴⁶ This also shows the advantage of universal application of healthcare services which in the long run will render healthcare cheaper, a lesson that should be learnt in Brazil. Regardless of these discrepancies, there can be no certainty in accuracy, as the “estimates are only as good as the assumptions and projections underlying them.”⁴⁷ The fact that such estimates create similar numbers, however, increases their chance of being accurate and on that basis we can move on to consider whether funding such scaling up of the healthcare system is even possible.

⁴⁴ Bryce J, Black, R. E., Walker, N., Bhutta, Z. A., Lawn, J. E., and Steketee, R. W., 'Can the world afford to save the lives of 6 million children each year?' (2005) 365 *The Lancet* 2193.

⁴⁵ World Health Organization (n 42) 116.

⁴⁶ *ibid* 117; see also Bryce J, and others (n 44) 2197-8.

⁴⁷ World Health Organization (n 42) 117.

The Lancet requiring US\$5 billion is 10% of what Ooms and Hammonds calculated is needed to provide US\$40 per person per year in 59 low to low-middle income countries, covering 2.5 billion people, to ensure a minimum core content of the right to health. Using the approximation of US\$50 billion, Ooms and Hammonds put this into perspective by highlighting the high income countries in the world as defined by the World Bank. At present, the number of high income countries is 75, and the total GDP amongst them is US\$50.45 trillion, covering a population of just 1.306 billion.⁴⁸ Thus with the approximation of US\$50 billion being needed to make such drastic changes to healthcare in the poorest countries in the world, whether very basic health interventions in 59 countries or universal child health coverage in 75 countries, only 0.1% of GDP from the most developed countries is needed, or 0.2% if we consider both of these estimates, or 0.01% GDP if we consider universally ensuring the necessary child health interventions. No matter which estimate is used, it is clear that a comparatively miniscule amount of money is required from the richest countries in the world to make exceptional changes to children's healthcare in the very poorest.

6.1.3 Requirement Under International Law

It is often argued that this form of international assistance is actually required under international human rights law,⁴⁹ and the CESCR has insisted that extra-territorial obligations arise from the ICESCR, although this is contentious, especially with non-compliant responses by the US.⁵⁰ The International Court of Justice did discuss

⁴⁸ The World Bank Data <<http://data.worldbank.org/income-level/HIC> last seen 24/07/2014>last viewed 07/04/2015.

⁴⁹ Ooms G, and Hammonds R (n 28) 35; Darrow M, *Between Light and Shadow* (n 16); Uriz GH (n 20) Clark DL, 'The World Bank and Human Rights: The Need for Greater Accountability' (2002) 15 Harvard Human Rights Journal 205.

⁵⁰ Craven M (n 29) 77.

extra-territorial obligations in the *Legal Consequences*⁵¹ case, however it refrained from discussing the obligations as imagined by Ooms and Hammonds. It merely stated obligations under ICESCR would extend to occupied territory even if not under a States' sovereignty.⁵² It is also argued that by opining that various provisions protected under ICESCR had been violated by Israel's construction of the wall, the International Court of Justice in fact confirmed the justiciability of ESC rights.⁵³ As will be recalled from chapter two, the obligation to progressively realise the right to health should be sought individually and through international assistance and cooperation wherever it is available and to the maximum possible.⁵⁴ With the accepted principle that 'ought implies can' which was highlighted in chapter three, and expresses the legal concept *ultra posse nemo obligator*,⁵⁵ no-one, or no country, can be obligated to do something that it is not possible for them to achieve.⁵⁶ It follows therefore, countries that fail to achieve the US\$40 per person per year spending of health (assuming that US\$40 is less than 3% of their GDP), are not violating international law by failing to achieve, at the very least, the minimum core of the right to health. However, the obligation to seek international assistance also falls under the *ultra posse nemo obligator* principle, in that the money must be available. If not, then countries cannot seek such assistance, which also means they cannot be violating international law as it is impossible to attain non-existent

⁵¹ *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territories (Advisory Opinion)* [2004] ICJ Rep, General List no 131 para 112.

⁵² *ibid.*

⁵³ Bates E, 'The United Kingdom and the International Covenant on Economic, Social and Cultural Rights' in Baderin M, and McCorquodale, R. (ed), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007) 283; see also *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territories (Advisory Opinion)* [2004] ICJ Rep, General List no 131 para 134.

⁵⁴ See especially section 4.2.1.1.

⁵⁵ Ooms G, and Hammonds R (n 28) 35, meaning 'no-one is obligated beyond what he is able to do'.

⁵⁶ Kant I, *The Critique of Pure Reason* (Electronic Classics Series 1787) 323; see also Rawls J, *A Theory of Justice: Revised Edition* (Oxford University Press 1999) 208; Wolff J, *The Human Right to Health* (Amnesty International Global Ethics Series, First edn, W. W. Norton & Company, Inc 2012); see also Brassington I (n 23) 79; see also Craven M (n 29) 81.

assistance. Therefore, if the right to health is to exist in practice, then there must be a corollary international obligation to provide such assistance, otherwise the right cannot be achieved, and is reserved solely for the privileged, and is purely formal.⁵⁷

International assistance was also sought in the Abuja Declaration when the African Union countries pledged to allocate at least 15% of their government spending to the health sector, yet in paragraph 28 the Declaration specifically states: "Africa cannot, from its weak resource base, provide the huge financial resources needed. In this regard, we urge those [donor] countries to, among others, fulfil the yet to be met target of 0.7% of their GNP as official Development Assistance (ODA) to developing countries."⁵⁸ The problems with ODA are vast and far reaching. Pogge highlights that in 2005 only \$7.63 billion of the total \$106.78 billion ODA went to basic services such as education or health, and suggests therefore that only 0.02% of the combined GNP of high-income countries goes towards poverty eradication.⁵⁹ Similarly, the WHO has pointed out that only 5 of the 22 donor countries to the ODA have reached the 0.7% GNI target,⁶⁰ and these targets were formalised and accepted by most countries at the G8 in 2004. In 2009, the average donation to ODA was just 0.36% of GNI, clearly showing a failure to achieve targets and an actual decrease in overall ODA over the previous 10 years.⁶¹ However it must be accepted that the donor countries are not alone in the failure to meet the targets to improve the health sector in some of the world's poorest countries. The declaration pledge of 15% of government spending on improving the health sector has only been achieved by one country, Tanzania, while 11 have actually reduced their

⁵⁷ Ooms G, and Hammonds R (n 28) 36; see also Brassington I (n 23) 29.

⁵⁸ Organisation of African Unity *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases* (2001) 28.

⁵⁹ Pogge T, *World Poverty and Human Rights* (n 4) 213.

⁶⁰ World Health Organization *The Abuja Declaration: Ten Years On* (2011; GNP is apparently used by the African Union whereas the donor countries more often use GNI.

⁶¹ *ibid.*

percentage spending on health since 2001.⁶² In 2011, the median level of government spending on health from domestic resources was US\$13.4 per capita in the countries involved in the Abuja Declaration, highlighting the problem of reaching the necessary funds and targets.⁶³ The report by the WHO highlights another funding issue by the IMF which suggests for every dollar transferred to sub-Saharan Africa for poverty reduction, only US\$0.27 was spent on this purpose while the rest was spent on debt reduction and foreign reserves.⁶⁴ Clearly, ways to ensure that the money goes towards its intended purpose, and also that the governments have no need or pressure to spend the money elsewhere, are greatly required. "Funding targets are being missed, both domestically and in terms of international assistance,"⁶⁵ so new ways to ensure the funds are available and used appropriately need to be considered.

Hammonds and Ooms have considered this issue and suggested that World Bank policies are too centred towards macroeconomics and development rather than looking at the impact and immediate effect their grants, loans and policies have and can have.⁶⁶ Wolff has also criticised some policies that have actually recommended restrictions on State spending on health which have proved a disaster in the poorest countries.⁶⁷ Hammonds and Ooms focus specifically on the World Bank institution of the International Development Association (IDA)⁶⁸ because of the regular funds the IDA receives from donor countries, thus making it the appropriate place to call for the changes they see as necessary and to assess the responsibilities of the donor

⁶² *ibid.*

⁶³ *ibid.*

⁶⁴ *ibid.*

⁶⁵ *ibid.*

⁶⁶ Hammonds R, and Ooms G, 'World Bank Policies and the Obligation of Its Members to Respect, Protect and Fulfill the Right to Health' (2004) 8 *Health and Human Rights* 27.

⁶⁷ Wolff J (n 56) 70.

⁶⁸ The other member of the World Bank is the International Bank for Reconstruction and Development (IBRD). This is not to be confused with the World Bank Group which contains five institutions: the IDA and IBRD, as well as three additional ones; the International Finance Corporation (IFC), the International Centre for Settlement of Investment Disputes (ICSID), and the Multilateral Investment Guarantee Agency (MIGA).

countries.⁶⁹ Also in many countries that rely on World Bank funding, the IDA remains one of the most influential actors and so change could have a large impact.⁷⁰ In their earlier 2004 paper, Hammonds and Ooms highlight the minimum core obligation for the right to health and the necessary US\$40 per person per year (per capita) the Commission on Macroeconomics and Health suggest.⁷¹ However, their objective is not just to highlight that despite spending 15% of government revenue on health many countries will still fall short of this required amount for a minimum core. In this paper Hammonds and Ooms seek to show that the policies of the World Bank actively prevent this achievement from being possible.

The World Bank use Poverty Reduction Strategy Papers (PRSPs), replacing Structural Adjustment Policies (SAPs), as their mechanism to decide on development aid as they provide national planning for the recipient countries.⁷² Alongside these, and regularly as part of the PRSPs, the World Bank will use Medium-Term Expenditure Frameworks (MTEFs) that impose budget ceilings and it is here the argument of actively preventing the fulfilment of a minimum core carries weight because these ceilings are substantially less than US\$40 per capita. These ceilings apply to both domestic and donor funds used in a country and are imposed to ensure the macroeconomic policies of the World Bank are adhered to. This exercise has been appropriately labelled 'grow now and realise human rights

⁶⁹ Hammonds R, and Ooms G (n 66) 30.

⁷⁰ Doebller CF, 'The Right to Health of Children and the World Bank' (2001) 5 Health and Human Rights 120, 141.

⁷¹ Commission on Macroeconomics and Health *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: WHO, 2001).

⁷² PRSPs replaced Structural Adjustment Policies (SAPs) that were popular in the 1980s with Margaret Thatcher and Ronald Regan pushing free markets and economic growth in developing countries. The idea is to grow first and then use that wealth to realise rights such as health. It proved an absolute disaster. It is argued as a fatal oversimplification of economic growth and in particular it was a disaster for health and led to large retrogression in many developing states; see Wolff J (n 56) chapter 4; Peabody JW, 'Economic Reform and Health Sector Policy: Lessons From Structural Adjustment Programs' (1996) 43 Social Science & Medicine 823; Darrow M, *Between Light and Shadow* (n 16) 70-72.

later.⁷³ The World Bank does not consider human rights fulfilment as a first priority and is more concerned that specific economic objectives are being achieved.⁷⁴ The World Bank has consistently stated that human rights are beyond its mandate as it should not be involved in politics, and in the past, has refused UN resolutions calling for removal of assistance to countries on human rights grounds. It is argued that this historical, non-political justification is no longer relevant.⁷⁵

The approach of the Bank means that in order to receive donor funds, a country must impose domestic ceilings on its budget in certain areas to accommodate the macroeconomic policies of the World Bank, with its budget being analysed line-by-line in some cases.⁷⁶ The donor funds the countries receive also have a ceiling on them that is so low there cannot be enough money to surpass the required amount for a minimum core. The only way a country could surpass this amount is by finding separate outside funds, which a report by the WHO and World Bank has suggested creates certain tensions between macroeconomic policies and expanding resources of the health sector.⁷⁷

In the fiscal year 2014, the World Bank had lending commitments of US\$40.84 billion for a range of projects, not just on health; down from an overall high of US\$58.75 billion in 2010.⁷⁸ As discussed above, the World Bank receives most of its finances from donor countries and members in exchange for votes and does not collect all the funds its members promise. This remaining money is known as 'callable capital'. This fund, which according to the World Bank website in 2015 stood at US\$178 billion, is money that the World Bank can call on should it need to

⁷³ Hammonds R, and Ooms G (n 66) 31.

⁷⁴ Doebller CF (n 70) 124.

⁷⁵ Uriz GH (n 20) 200, 202, 225.

⁷⁶ *ibid* 208.

⁷⁷ World Health Organization and The World Bank, *Resources, Aid Effectiveness, and Harmonization* 'High-Level Forum on the Health Millennium Development Goals' (2003) 3; see also Hammonds R, and Ooms G (n 66) 43-44.

⁷⁸ <<http://www.worldbank.org/projects>>last viewed 02/02/2015.

(which it never has to date).⁷⁹ It is argued that international law requires such funds to be made available to those countries that cannot afford the minimum core requirements, and also that SAPs from the 1980s and now PRSPs, along with other examples such as the release of political opponents in Chad after pressure from the World Bank President, show that the Bank is not afraid to use its influence and leverage to have an impact.⁸⁰ The legal obligations of the World Bank are often scrutinised because many of its members have ratified the ICESCR and the CRC. Indeed most scholars have argued that the World Bank and IMF have a basic obligation to respect human rights,⁸¹ but for Hammonds and Ooms the obligations go further.⁸² It has been suggested that the obligation stems from the UN Charter and customary international law, but a stronger conclusion can be reached by considering all binding international treaties and conventions, including the CRC, as comparable to an international constitution.⁸³ It is argued that as shareholders in the Bank, the member States can, and have a responsibility to change Bank policy and funding to ensure a minimum core. The particular language used by the Committee on Economic, Social and Cultural Rights in General Comment 14 reiterates and highlights this point:

States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.⁸⁴

⁷⁹ <http://web.worldbank.org/WBSITE/EXTERNAL/EXTSITETOOLS/0,,contentMDK:20147466~menuPK:344189~pagePK:98400~piPK:98424~theSitePK:95474,00.htm> last viewed 04/05/2015.

⁸⁰ Clark DL (n 49) 211; Uriz GH (n 20) 209.

⁸¹ Klabbers J, 'Constitutionalism Lite' (2004) 1 International Organizations Law Review 31, 34; Darrow M, *Between Light and Shadow* (n 16); Hammonds R, and Ooms G (n 66).

⁸² Darrow M, *Between Light and Shadow* (n 16) 133.

⁸³ *ibid* 136.

⁸⁴ Committee on Economic, Social and Cultural Rights *General Comment No. 14 - the Right to the Highest Attainable Standard of Health* (2000) 39.

Here, these ideas are taken further by calculating that members of the World Bank, more particularly the IDA, that have ratified the CRC control 89.26%⁸⁵ of the voting shares and thus the prospect of changing the Bank is not impossible for fear of a veto by the United States. The obligation to influence the policies of the World Bank can be clearly seen as its members have ratified conventions to impose those obligations upon themselves. The retrogression of funds from the Bank in the last 4 years, along with the arguments made above that US\$50 billion per person per year extra spending on healthcare would achieve a minimum core which is affordable as 0.1% GDP of the richest countries in the world, supports the obligation to change the World Bank and provide these funds. The current policies by the World Bank impose a ceiling on the amount of funds countries can receive and spend on healthcare and it can be convincingly seen that the Bank's policies actually render it impossible for some countries to achieve a minimum core standard of healthcare.⁸⁶ This surely amounts to a violation of international obligations by the World Bank.

The theoretical foundations to support this are established by Pogge's thesis of global injustice and a violation of the negative duty not to unduly harm, as well as the idea of a global difference principle requiring the position of the worst off to be better off if any inequalities are to be fair and just. The legal foundations are found in international law and the requirement that international assistance be sought, and must therefore be available. With such a small burden on the richest countries in the world, 0.1% of GDP leading to an increase in funds of US\$50 billion which could drastically change the lives of every child in the 75 countries with the highest infant mortality rate, a Global Health Fund, a Global Resources Dividend, or drastic change to the World Bank policies by member States stepping up, needs to be

⁸⁵ As highlighted in chapter four, only two countries have not ratified the CRC; the United States and Somalia. The United is the largest shareholder with 10.70% of the IDA vote, Somalia has 0.04, totaling 10.74%. See <<http://go.worldbank.org/J0UEXULT20>>last viewed 22/12/2014.

⁸⁶ Hammonds R, and Ooms G (n 66).

established sooner rather than later. It would however be naive to think that this alone will solve the problem. If the United States serves as an example of anything when it comes to healthcare, it is that merely throwing money at the problem is not a panacea.⁸⁷ Therefore, ways to enforce international law and ensure governments make progressive steps to ensure every child has access to quality healthcare services need to be considered.

6.2 Enforcing a Child's Right to Healthcare

The thesis began with an overview of healthcare systems to show the need for this obligation to be taken up seriously, even in the richest country in the world where the minimum core is not being fulfilled. The moral underpinnings of a child's right to healthcare have been established using Rawls' theory of justice in chapter four and extending the principle of equality of opportunity before it was globalised as a necessary part of Rawls' theory to ensure a global difference principle. This means the obligation of securing a minimum standard of a child's healthcare lies with the international community as well as with the State within which the child happens to be born. In this chapter, it has been demonstrated that this international obligation would not impose too much of a financial constraint on the world and that this distribution of funds is part of international law. It is clear however, that despite the ease with which a considerable difference could be made to so many children's lives by providing the international assistance required to ensure socio-economic rights, this is not occurring. It is also clear that in some countries the right to health is being ignored for reasons other than resource constraints. So discussion must

⁸⁷ *ibid* 29.

now move to what can be done to ensure that this right is realised and enforced in all countries in the world, and how international law and a child's right to healthcare can be transformed into a tangible right as opposed to an idealistic goal on a piece of paper. The first step of achieving this will be discussion of international law as possible superior constitutional law in order to allow greater enforcement. If this area of academic discourse can unite behind one single definition which imposes supremacy of international law enforced by a World Court, then international human rights law could become tangible guarantees.

6.2.1 The Status of International Law

Perhaps one of the most convincing methods of accepting international human rights law as a way of ensuring tangible, enforceable rights is to think of human rights and the international instruments much like an international constitution. It is argued that the international community definitely has a constitution⁸⁸ and so it must be asked which parts, if any or all, of international law forms this. The advantage of conceiving international law as constitutional, and the use of constitutional vocabulary, is that failures and violations then become objective wrongs⁸⁹ and the rights included therefore must have a remedy.⁹⁰ Indeed, on such a viewpoint treaties 'trump' any inconsistent national laws, and if this is accepted by the courts, those treaties take on the status of a constitution.⁹¹ However, the legal status of international law can be contentious as some argue that the absence of hard

⁸⁸ Fassbender B, 'The United Nations Charter As Constitution of The International Community' (1998) 36 Columbia Journal of Transnational Law 529, 584.

⁸⁹ Koskeniemi M, 'Constitutionalism as Mindset: Reflections on Kantian Themes About International Law and Globalization' (2007) 8 Theoretical Inquiries in Law 9, 35.

⁹⁰ Blackstone W, *Commentaries on the Laws of England: Book the Third* (1809) 23.

⁹¹ Ackerman B, 'The Rise Of Global Constitutionalism' (1997) 83 Virginia Law Review 771, 775-776.

enforcement and democratic deficit render it not real law.⁹² HLA Hart famously questioned whether international law was really law in his concept of laws. The criticism is that international law lacks the characteristics to be law by lacking effect. Not everyone shares Hart's view. Peters for example, points out that a State's Constitutional law may not be directly enforceable and lack hard enforcement through the courts, yet is undeniably seen as law, as an analogy to giving international law its legal status.⁹³ Drake also argues that a lack of effectiveness is no objection to legal character but merely international laws development, and the suggested changes made later using the example of European law and its constitutional supremacy, show this impotence can also change.⁹⁴ There is also the criticism of a lack of legitimacy in international human rights which needs to be countered to allow for effective enforcement methods to be proposed.⁹⁵ This is addressed at the same time as the arguments that establish the constitutional status of international law, to also support its legal legitimacy.

Fassbender highlights one of the main difficulties engaging with such discussion being that 'Constitution' is well-defined as regards the States, but in terms of international law and the international community it has yet to become a clearly defined category.⁹⁶ Yet it is counter-argued that a 'constitution' is not solely defined as regards the State.⁹⁷ Fassbender suggests that international constitutionalism

⁹² Peters A, 'The Merits of Global Constitutionalism' (2009) 16 *Indiana Journal of Global Legal Studies* 397, 401, 405.

⁹³ Peters A, 'The Merits of Global Constitutionalism' (n 92) 405.

⁹⁴ Hart HLA, *The Concept of Law* (Second edn, Clarendon Press 1994), 214 'It is indeed arguable, as we shall show, that international law not only lacks the secondary rules of change and adjudication which provide for legislature and courts, but also a unifying rule of recognition specifying 'sources' of law and providing general criteria for the identification of its rules. These differences are indeed striking and the question 'Is international law really law?' can hardly be put aside.'; Drake JG, 'Monism and Dualism in the Theory of International Law' in Paulson SL, and Paulson BL, (ed), *Normativity and Norms: Critical Perspectives on Kelsenian Themes* (Oxford University Press 1999) 540-541.

⁹⁵ Brown C, 'Universal Human Rights: A critique' (1997) 1 *The International Journal of Human Rights* 4153; Peters A, 'The Merits of Global Constitutionalism' (n 92) 405.

⁹⁶ Fassbender B (n 88) 552.

⁹⁷ Peters A, 'The Merits of Global Constitutionalism' (n 92) 402.

may be a paradigm shift from the old view of international law based on State sovereignty where law is only binding because of consent, to a view where consent of the State is not required as the legal order must be respected by every member of the community, as seen in Europe.⁹⁸ Peters makes a similar point arguing that a gradual shift is occurring rendering sovereignty less important as its basis is understood to arise from humanity and human rights.⁹⁹ This will be further discussed below when establishing the content of a global constitution and the inquiry into the standing of human rights.

Another concern for the idea of a global constitutionalism or an international constitution is that it raises objections about creating a false legitimacy as well as the unrealistic and impractical expectations of what it may achieve.¹⁰⁰ The legitimacy concerns can be addressed fairly simply by constitutional moments suggested by many authors, as they clearly show the intention of the drafters to create a new legal order in a constitution-like manner.¹⁰¹ It cannot be denied that there has been a constitutional moment for every UN treaty and convention in a similar way to the constitutional moment which established the US constitution. Not every American was present. Not every American had a say. Not every American will have agreed to every element of the constitution. But it was a clear moment of constitutional agreement and the legitimacy of its law is not in doubt. Equally such fears can be assuaged because the aim of global constitutionalism is not to over reach on its legitimacy. "The idea is not to create a global, centralized government, but to constitutionalize global, polyarchic, and multilevel governance."¹⁰²

⁹⁸ Fassbender B (n 88) 617.

⁹⁹ Peters A, 'The Merits of Global Constitutionalism' (n 92).

¹⁰⁰ *ibid* 407; Klabbers J (n 81) 47.

¹⁰¹ Fassbender B (n 88) 573; Ackerman B (n 91).

¹⁰² Peters A, 'The Merits of Global Constitutionalism' (n 92) 404.

An additional criticism connected to this, is that current constitutional thought is very much a Western ideology and therefore it would be inappropriate to apply this globally. However, Fassbender argues, in much the same way as was done in the previous chapter in connection to globalising Rawls, that there is an overlapping consensus of minimal values which would create a common constitutional stock that can be used.¹⁰³ It is also argued that this stock is much more substantial than we are normally led to believe. If this common crossover is accepted, especially at a minimal level then Fassbender contends that an international constitution has a good chance of succeeding, as there is no attempt to form a world government, but merely realise basic rights in a framework we universally label as constitutional.¹⁰⁴

The contention here is to find a way to directly enforce international law by comparing it to a constitution, drawing on the examples discussed in chapter three and the right to healthcare in written Constitutions. Whilst the international human rights instruments were not specifically designed to be a Constitution, the UDHR, the ICCPR, and the ICESCR, are collectively known as the International Bill of Rights.¹⁰⁵ The constitutionalisation of international law is an emerging area of academic discussion and it will be shown to have teething problems, nevertheless the aim remains to view the basic international human rights instruments as constitutional, with a doctrine of supremacy allowing them to be enforced by an overarching world court.

¹⁰³ Fassbender B (n 88) 553-554.

¹⁰⁴ *ibid* 555.

¹⁰⁵ Kinney ED, 'Recognition of the International Human Right to Health and Health Care in the United States' (2008) 60 Rutgers Law Review 335, 339; see also Smith RKM, *Textbook on International Human Rights* (Sixth edn, Oxford University Press 2014) 30, 37; see also Mann J, Gostin, L., Gruskin, S., Brennan, T., Lazzarini, Z., and Fineberg, H. V., 'Health and Human Rights' (1994) 1 Health and Human Rights 7, 10.

6.2.2 Global Constitutionalism

6.2.2.1 Definition

The first main point to consider about global constitutionalism is that there is no one definition; no one is certain exactly what it is and debate is rarely coherent and is full of contradictions,¹⁰⁶ with even the purpose of global constitutionalism being questioned and far from straightforward.¹⁰⁷ Indeed to begin with there is no precise definition and agreement on constitutionalism.¹⁰⁸ It is suggested that constitutionalism is the unwritten, flexible principles underlying a constitution, which is a living document, with some arguments that this has already happened on the international level with human rights.¹⁰⁹ Whilst it is argued that precise agreement on a definition is highly desirable, it remains clear this has not yet happened.¹¹⁰ In this search for a clear definition it is argued that global constitutionalism needs to be recognised more in academic circles.¹¹¹

Fassbender has highlighted three main schools of thought on different approaches to the idea of constitutional law of the international community; firstly, a monism assuming a unity of law based on Kelson's basic norm and the constitution of a universal community of States based largely on customary law with some formal constitutional instruments; secondly, one that differs between constitutional and constitutive processes and finds international treaties and charters as part of an ongoing constitutive process, but not a normative international constitution; thirdly, that of the international community which consists of States and organisations as a community governed by law which can become a formal constitution of the

¹⁰⁶ Ackerman B (n 91) 538.

¹⁰⁷ Weiner A, Lang AF, Tully J, Maduro MP, and Kumm M, 'Global constitutionalism: Human rights, democracy and the rule of law' (2012) 1 *Global Constitutionalism* 1, 4.

¹⁰⁸ Klabbbers J (n 81) 32.

¹⁰⁹ D'Souza C, 'World Constitutionalism' in D'Souza A, and D'Souza C, (ed), *World Constitutionalism* (Cambridge Scholars Publishing 2007) 4.

¹¹⁰ Weiner A, et al (n 107) 4, 6.

¹¹¹ D'Souza C (n 109) 5.

community, which differs from the first school through a focus on community law as opposed to monism.¹¹² Fassbender argues that discussion in this area suffers from terminological confusion where, in the international sphere, constitution is not yet a defined category.

Peters suggests global constitutionalism is a continuing gradual emergence of constitutional elements in the international order supported and encouraged by academics.¹¹³ She discusses the connection between sovereignty and international law mentioned above and the gradual shift towards global constitutionalism.¹¹⁴ She argues this shift is progressively and slowly happening as international law gains more constitutional acceptance and in turn reduces the importance of sovereignty once held. Sovereignty, as the first and most important principle of international law, is being ousted as the focus shifts from State's rights to their human rights obligations. This is happening because increasingly sovereignty is seen to come from humanity and the legal principle of respecting human rights.

Peters argues that the justification of State sovereignty comes from the fulfilment of basic human needs. State's respect for each other's sovereignty is horizontal as opposed to a humanised sovereignty which exists in an ontological sense:

When human needs are taken as the starting point, the focus shifts from states' rights to states' obligations vis-à-vis natural persons, and a state that does not discharge these duties has its sovereignty suspended. The possibility of a suspension of state sovereignty leads, in a system of multilevel governance under the principle of solidarity, to a fallback responsibility of the international community, acting through the U.N. Security Council.¹¹⁵

¹¹² Fassbender B (n 88).

¹¹³ Peters A, 'The Merits of Global Constitutionalism' (n 92); Dunoff JL, Wiener A, Kumm M, Lang AF, Tully J, 'Hard times: Progress narratives, historical contingency and the fate of global constitutionalism' (2015) 4 Global Constitutionalism 1, 12.

¹¹⁴ Peters A, 'The Merits of Global Constitutionalism' (n 92).

¹¹⁵ Peters A, 'The Merits of Global Constitutionalism' (n 92) 398-399; Peters A, 'Humanity as the A and Ω of Sovereignty' (2009) 20 The European Journal of International Law 513.

Humanising sovereignty, according to Peters, is an ongoing process that is vital to an international legal system centred on individuals. The international legal order is not exclusively based on State sovereignty anymore, with the introduction of 'responsibility to protect'¹¹⁶ a major step in ousting its importance.¹¹⁷ Fassbender has also argued for this paradigm shift where consent of the State is not seen as required anymore.¹¹⁸ Whilst the shift may be occurring gradually, it is argued that the first school is much more the intention of the formal international instruments; a constitution of a universal community of States. Equally important is the need for those instruments to be included in global constitutionalism so as to include human rights. Scholars differ on whether human rights can and should be included in any thoughts surrounding global constitutionalism, and through discussing possible content, more clarity on the definition may arise.

6.2.2.2 Content

Those elements of international law which are argued to have constitutional rank can be determined by looking at literature on global constitutionalism. For some it is argued that the broadly defined idea of 'global constitutionalism' will reject the UN Charter or human rights treaties as a written constitution because this would be seen as an attempt to revive antiquated notions of formalism and normativism. Global constitutionalism, as Fassbender understands it, comprises of various values, norms, practices and institutions for example, as opposed to a visible written

¹¹⁶ This was endorsed by all member states of the United Nations at the 2005 World Summit to prevent genocide, war crimes, ethnic cleansing, and crimes against humanity. The principle entails a responsibility to protect all populations from mass atrocity crimes and human rights violations. The principle is based especially on the underlying principles of law relating to sovereignty, peace and security, human rights, and armed conflict. See, United Nations General Assembly, 'Early warning, assessment and the responsibility to protect, Report of the Secretary-General' (2010) A/64/864.

¹¹⁷ Peters A, 'Humanity as the A and Ω of Sovereignty' (n 115) 514.

¹¹⁸ Fassbender B (n 88) 617.

document. Fassbender argues that such a written constitution offers an authoritative statement of rights and responsibilities of members.

An alternative view is provided by Gardbaum who contends it is undeniable that there is “something inherently constitutional about human rights law”.¹¹⁹ Despite this quote, he is less convinced that International Human Rights Law, as opposed to EU law, has constitutional quality. He contends that there are three fundamental characteristics which render something constitutional law. It must be: made by a special constituent power; considered higher law; and only able to be amended or repealed by the authority that created it.¹²⁰ Below (6.2.2.3) it will be seen how Gardbaum argues at length that EU law definitely has these qualities, whereas for global human rights he suggests that the UN Charter and the International Bill of Rights have the strongest claims to being “products of constitutional moments”.¹²¹

6.2.2.2.1 The UN Charter

Peters warns against including all international law as constitutional law because then nothing becomes constitutional, and it is detrimental to inflate the current international system to such an extent.¹²² The explicit claim of constitutionalisation of international law tends to focus more on customary international law and the UN Charter,¹²³ neither of which have human rights as a central element. Indeed it is argued by many that the UN Charter and the EU’s treaty framework have

¹¹⁹ Gardbaum S, 'Human Rights as International Constitutional Rights' (2008) 19 *European Journal of International Law* 749, 753; see also Möller K, 'From constitutional to human rights: On the moral structure of international human rights' (2014) 3 *Global Constitutionalism* 373, 374.

¹²⁰ Gardbaum S (n 119) 753-4.

¹²¹ *ibid* 756.

¹²² Peters A, 'The Merits of Global Constitutionalism' (n 92) 403.

¹²³ Klabbbers J (n 81) 32.

constitutional quality holding a position that enhances Kantian regulative ideas of international conventions as constitutions.¹²⁴

Whilst the content of any international constitution is argued, especially as regards human rights, it is largely accepted that if there is one, the UN Charter is undoubtably part of it.¹²⁵ Some would argue it is *the* international constitution,¹²⁶ as opposed to others who suggest it is part of several documents that make up the constitution of the international community.¹²⁷ Fassbender contends it is the supporting frame of all international law and the highest level in the aforementioned hierarchy.¹²⁸ The notion of comparing the UN Charter to a constitution started as early as the final session of its adoption when US President Harry Truman stated that it is a constitution that grows, develops and expands over time.¹²⁹ Indeed the Charter has the features that have been suggested as necessary for a constitution, such as being established by a special body and that it cannot be amended ordinarily but only by special means.¹³⁰ This itself is a distinction between a normal treaty and one with constitutional status, as a treaty may be changed via customary law without editing the text as opposed to a constitution that can only be amended through special procedures.¹³¹ Fassbender has discussed the differing views on the position of the Charter in international law and its binding nature. Some authors

¹²⁴ Weiner A, et al (n 107) 7.

¹²⁵ Reisman WM, 'The Constitutional Crisis in the United Nations' (1993) 87 *The American Journal of International Law* 83, 100; Klabbers J (n 81).

¹²⁶ Gardbaum S (n 119); Fassbender B (n 88).

¹²⁷ Tomuschat C, 'Obligations Arising for States Without or Against their Will' (1993) 241 *Rec Des Cours* 195.

¹²⁸ Fassbender B (n 88) 585.

¹²⁹ Harry S. Truman's Address in San Francisco at the Closing Session of the United Nations Conference, 26th June 1945; 'The Constitution of my own country came from a Convention which--like this one--was made up of delegates with many different views. Like this Charter, our Constitution came from a free and sometimes bitter exchange of conflicting opinions. When it was adopted, no one regarded it as a perfect document. But it grew and developed and expanded. And upon it there was built a bigger, a better, a more perfect union. This Charter, like our own Constitution, will be expanded and improved as time goes on. No one claims that it is now a final or a perfect instrument. It has not been poured into any fixed mold. Changing world conditions will require readjustments'.

¹³⁰ Fassbender B (n 88) 535.

¹³¹ *ibid* 600.

uphold the principle that a treaty cannot bind a non-member State against its will,¹³² whereas others suggest States live with basic rules from their creation which determines their rights and obligations with or without their will.¹³³ Tomuschat is firmly of the opinion that the UN Charter is part of the international constitution, but one of several world order treaties, which has constitutional rank because it relates to the basic functions of governance. Fassbender suggests that the two Human Rights Covenants can be attributed constitutional rank if they characterise in detail and further develop the constitutional law of the Charter.¹³⁴ This becomes difficult as the Covenants develop the declaration adding greater detail and develop its constitutional character. It is contended here that the universal acceptance of the declaration gives it constitutional status and therefore rather than argue that the Covenants are developing the constitutional character of the charter, it is contended here the same argument can apply to the declaration. This therefore allows for more State obligations, including the provision of medical care. However, such a human right being part of the international constitution is not free of critics.

6.2.2.2.2 Human Rights

Gardbaum suggests some weaknesses in claiming humans rights as part of an international law constitution: firstly, they make individuals objects and not subjects; they do not bind countries against their will; and they do not bind international organisations.¹³⁵ Indeed the changing status of individuals under international law is a direct response to the atrocities of World War II and the formation of human rights.¹³⁶ These ideas also echo the second characteristic of Gardbaum's characteristics of constitutional law; that to be constitutional it should be considered

¹³² Mosler H, *The International Society as a Legal Community* (Sijthoff & Noordhoff International Publishers 1980).

¹³³ Fassbender B (n 88) 549; Tomuschat C (n 127).

¹³⁴ Fassbender B (n 88) 588.

¹³⁵ Gardbaum S (n 119) 763.

¹³⁶ Dunoff JL, and others (n 113) 10.

'higher law', which has its roots in the work of Hans Kelson and his 'basic norm'. As is well known, for Kelson a Constitution's validity comes from its basis in a basic norm that has been constructed by logical inference.¹³⁷ This *Grundnorm* is at the top of the hierarchy of laws but is not the Constitution itself. In essence it informs the Constitution which then becomes the formal top of the hierarchy. This was the beginning for formal Constitutional hierarchy,¹³⁸ which is where a world constitution should aim to be.

However, the failure of the US to ratify several treaties illustrates part of the problem with human rights as part of international constitutional law, because they clearly do not bind a country against its will. Included in this argument against human rights being part of a global constitution is the weak enforcement even when a treaty is ratified.¹³⁹ Yet none of these reasons defeats the possibility of human rights becoming part of an international constitution that all countries and international institutions, such as the World Bank, would legally have to abide by. For the purpose of effectiveness and the desire to make human rights tangible guarantees not words on paper, it is therefore important to question whether further constitutionalisation of international organisations would help,¹⁴⁰ and if so, how we might go about achieving this.

Möller uses the above arguments on the basis of sovereignty to point to a State's obligation to join an international system that protects human rights, because each State has obligations to people in other States. This obligation arises by virtue of their humanity.¹⁴¹ This status of humanity, or human dignity, is a moral concern, violation of which cannot be defended merely by a claim to sovereignty. Thus, every

¹³⁷ Fassbender B (n 88) 533.

¹³⁸ Eleftheriadis P, 'Aspects of European constitutionalism' (1996) 21 *European Law Review* 32, 34-36.

¹³⁹ Peters A, 'The Merits of Global Constitutionalism' (n 92) 405.

¹⁴⁰ Weiner A, and others (n 107) 11.

¹⁴¹ Möller K (n 119) 400.

State is under an obligation to ensure human dignity and human rights are upheld in all States which requires involvement in international systems of rights protection.¹⁴²

The argument is made that sovereignty is now a second-order norm, which is derived from and at the same time geared towards the protection of basic human rights.¹⁴³ The possible power to rescind authority from those States that fail their obligations towards their citizens is an important element of human rights possibly being part of a global constitution. States have responsibilities, duties and powers granted to them by the international community, which at least in theory, can also be curtailed and rescinded by a more supreme international law. This may be wishful academic thinking as it appears to lack political support, a fact which Peters accepts as a problem with global constitutionalism and its challenge to navigate the gap between dignifying the status quo and academic pipe dreams.¹⁴⁴

To counter arguments that a constitution with a strong place for human rights cannot apply internationally, the example of Europe has been referred to many times and serves as the appropriate way to defeat the idea that international law cannot have a constitutional nature and even if it could be argued that it did, it would be impractical and give false hopes of the end of political debate.¹⁴⁵ This argument is combined with concerns that global constitutionalism will give rise to a rigid system that does not accept differences between societies and that any global constitution must be anti-pluralist.¹⁴⁶ This can be countered by arguing that the aim of global constitutionalism is not to create a world government but to be minimal, giving effect to only those principles on which there is overlapping consensus. In

¹⁴² *ibid* 401.

¹⁴³ Peters A, 'Humanity as the Alpha and Omega of Sovereignty' (n 115) 544.

¹⁴⁴ Peters A, 'The Merits of Global Constitutionalism' (n 92) 402.

¹⁴⁵ *ibid* 407; Klabbbers J (n 81) 47; Tushnet agrees with the falsity of ending political debate because all discussion of these constitutional values is themselves political, however this is where Tushnet argues that constitutional theory by its very nature is impossible, Tushnet M, 'Darkness on the Edge of Town: The Contributions of John Hart Ely to Constitutional Scholarship' (1980) 89 Yale Law Journal 1037.

¹⁴⁶ Peters A, 'The Merits of Global Constitutionalism' (n 92) 403.

Europe, EU law has clearly established itself as a supreme constitution, which acts as a minimum a State cannot fall below. States themselves can go beyond this minimum and the exact method of fulfilment of a right is left to the governments of Europe. This gives rise to political debate on how best to achieve the rights laid down in a supreme European constitution. First it will be discussed how the EU established a supreme constitutional law, which is similar to the way Fassbender understands global constitutionalism as mentioned in 6.2.2.1.

6.2.2.3 The Example of Europe

EU law and the human rights contained within being universally acknowledged as constitutional law demonstrate that constitutionalism is not exclusively limited to the national, sovereign State setting anymore.¹⁴⁷ Peters also argues that EU and European Court of Human Rights treaty regimes are among the top of all constitutional regimes,¹⁴⁸ and serve as the most successful example of constitutionalisation.¹⁴⁹ EU law, Gardbaum suggests, also contains the three of the fundamental characteristics of constitutional law mentioned above.¹⁵⁰ It is the supremacy of EU law that is the most important reason for attributing constitutional status, a status that was established by the Court of Justice of the European Union in *Costa v ENEL*.¹⁵¹ In accordance with Article 177 of the Treaty of Rome,¹⁵² the Court of the Justice of the Peace of Milan referred the case to the European Court of Justice because of uncertainty about treaty interpretation. The case concerned the nationalisation of a former private electricity company and whether this

¹⁴⁷ Fassbender B (n 88) 558.

¹⁴⁸ Peters A, 'The Merits of Global Constitutionalism' (n 92) 402.

¹⁴⁹ Weiner A, and others (n 107) 5.

¹⁵⁰ Gardbaum S (n 119) 753-4.

¹⁵¹ Case 6/64 *Flaminio Costa v Ente Nazionale per l'Energia Elettrica* (ENEL) (1964) ECR 585.

¹⁵² *Treaty establishing the European Economic Community* (1957).

breached EU law established by the Treaty. The Italian Government however, argued that the request was inadmissible as this was an issue of national law and should be decided in a national court which cannot avail itself of Article 177.¹⁵³ Mangold argues that in response to this position, the CJEU more or less invented the doctrine of supremacy, declaring the EEC Treaty to have its own legal system integral to the systems of Member States.¹⁵⁴

The Court went on to make the point that by establishing the European Community with its institutions, the member States have accepted to give up some of their sovereignty and created a law which binds themselves as well as their citizens, making it more than a technical question, but rather a presupposition of the legal order.¹⁵⁵ With these ideas, the Court then firmly established supremacy over domestic law affirming that “law stemming from the Treaty . . . could not, because of its special and original nature, be overridden by domestic legal provisions, however framed”.¹⁵⁶ Thus the Court also ensured that the community law established by the Treaty did not differ from one State to another after ratification.

It is from this decision that the principle of the supremacy of EU law has been established as one of the EU's central doctrines,¹⁵⁷ and which Gardbaum argues is the most important of the three criteria to EU law having a constitutional nature.¹⁵⁸ It is obvious from *Costa* that the Treaty of Rome was not created or established in a

¹⁵³ Mangold AK, 'Costa v ENEL (1964): On the Importance of Contemporary Legal History' in Domeier N, Augusti, E., Prutsch, M., and von Graevenitz, F. G. (ed), *Inter-Trans-Supra?: Legal Relations and Power Struggles in History* (AkademikerVerlag 2011) 226; see also Case 6/64 *Flaminio Costa v Ente Nazionale per l'Energia Elettrica* (ENEL) (1964) ECR 585.

¹⁵⁴ Case 6/64 *Flaminio Costa v Ente Nazionale per l'Energia Elettrica* (ENEL) (1964) ECR 585, 593; see also Mangold AK (n 152) 226.

¹⁵⁵ Eleftheriadis P, 'Begging The Constitutional Question' (1998) 36 *Journal of Common Market Studies* 255.

¹⁵⁶ Case 6/64 *Flaminio Costa v Ente Nazionale per l'Energia Elettrica* (ENEL) (1964) ECR 585, 594.

¹⁵⁷ Eleftheriadis P, 'Aspects of European constitutionalism' (n 138) 32.

¹⁵⁸ Gardbaum S (n 119) 753-5.

'constitutional moment' with the view of being a constitution for Europe,¹⁵⁹ which it has been suggested would be necessary for constitutional status. Despite this, it is clear that over the next few decades the Treaty of Rome has become a constitutional document for Europe, achieved through development of the doctrines of supremacy and direct effect in the Court of Justice.¹⁶⁰ The European Court of Human Rights has exercised similar jurisprudence in determining that the document they base their jurisdiction upon has a constitutional character in Europe.¹⁶¹ This was argued in *Ireland v UK* (1978)¹⁶² where the European Convention was given constitutional status.

It is clear that the Courts have stated the superiority of European laws and independence from the law of member States, but Eleftheriadis argues it is unclear what, if any, doctrinal basis this has.¹⁶³ The European court has skilfully avoided these questions and as such its constitutional nature is more practical than philosophical. The European Court argues for a single European legal order where the Treaties are the highest source of law with superiority in all conflicts. This is a monist approach, however, the German Constitutional Court argues for a dualist approach in Europe where the Treaty law is not superior but becomes valid only because the national Constitution allows it. Both approaches are found in respect to international law but if there is to be a single legal order with a clear hierarchy, then they cannot both be right at the same time. Both occur in the context of European

¹⁵⁹ Ackerman B (n 91) 34.

¹⁶⁰ Eleftheriadis P, 'Aspects of European constitutionalism' (138); see also Ackerman B (n 91) 793.

¹⁶¹ Klabbers J (n 81) .

¹⁶² 2 EHRR 25, 239 "unlike international Treaties of the classical kind, the Convention comprises more than reciprocal engagements between contracting States. It creates, over and above a network of mutual, bilateral undertakings, objective obligations which, in the words of the Preamble, benefit from a "collective enforcement.""; see also *Loizidou v Turkey* (1998) 20 EHRR 99, 75; see also; Pollicino O, 'The European Court of Human Rights and the Italian Constitutional Court: No 'Groovy Kind of Love' in Ziegler KS, Wicks E, and Hodson L, (ed), *The UK and European Human Rights: A Strained Relationship?* (Hart Publishing 2015) 377

¹⁶³ Eleftheriadis P, 'Aspects of European constitutionalism' (n 138) 37.

law, so there is in fact no single coherent legal order within the European Community which is, theoretically a problem still unresolved.¹⁶⁴

In spite of this, the enforcement and implementation problems experienced in international law are not experienced in EU law which undoubtedly has become a regional constitution.¹⁶⁵ Therefore, the success of Europe can still provide a valuable lesson to international human rights law and finding ways to make that more constitutional in nature to provide enforceable law through the courts. The hierarchy of law in Europe still has questions that need answering, yet it remains a step in the right direction for international law to take. If the theoretical questions of European law were the only questions international law needed to answer, there would be much greater implementation of human rights.

One of the main reasons behind the success of the EU is the transition of international treaty law from the normal horizontal elements¹⁶⁶ to a vertical, supranational entity, establishing supremacy of its law.¹⁶⁷ It is the paradigm of constitutional international law, with supranational status and a court with compulsory jurisdiction.¹⁶⁸ The creation of a direct effect of hard EU law,¹⁶⁹ along with the establishment of supremacy, has led to a supranational system of international law with limited sovereignty for the member States to depart from this body of law. The key to this change was the recognition of the Treaty of Rome as the highest source of law, which Eleftheriadis argues created the hierarchy of

¹⁶⁴ Eleftheriadis P, 'Begging The Constitutional Question' (n 155).

¹⁶⁵ Darrow M, 'Human Rights Accountability of the World Bank and IMF: Possibilities and Limits of Legal Analysis' (2003) 12 Social & Legal Studies 133, 136.

¹⁶⁶ As the initial principle of international law and ultimate respect for state sovereignty; see Peters A, 'The Merits of Global Constitutionalism' (n 92) 398.

¹⁶⁷ Gardbaum S (n 119) 759.

¹⁶⁸ *ibid.*

¹⁶⁹ Established in 1963 in *Van Gend en Loos v Nederlandse Administratie der Belastingen* (26/62) [1963] ECR 1. Mangold argues that the ECJ were aware of the connections between direct effect and supremacy but deliberately did not consider supremacy at the same time because of the politics of these decisions and the Court wanted to spread them out so that they could ease their way in to EU politics. See Mangold AK (n 153) 228-9.

European legal norms, with the central European *Grundnorm* at the top.¹⁷⁰ It has been suggested that the Court specifically moved to create this system; “the Court as early as 1963 had a concept for the legal arrangement of Community law’s consequences: Only direct effect and supremacy of Community law together could establish its “supranationality””.¹⁷¹ This transformation from a traditional private law concept of horizontal relations between sovereign equals has been replaced by the public law model of vertical supranational relationships between States and individuals, showing the constitutional nature of EU law.¹⁷² Gardbaum argues that part of this shift is the compulsory jurisdiction of an international court and that: “consent to compulsion is also typified by the EU.”¹⁷³ Applying this idea more specifically to human rights, it is argued that the European Convention on Human Rights (ECHR) has reached the same levels of constitutionality as EU law despite not requiring incorporation into domestic law. This is because certain compulsory factors have led to de facto incorporation and acceptance because: “Compulsory jurisdiction of human rights courts, in the strong sense as a condition of membership, remains limited to the ECtHR”¹⁷⁴. The CJEU also has compulsory jurisdiction over member States as a condition of EU membership, yet the ECtHR is the best example for human rights specifically. As part of the ratification of treaties and conventions, which is necessary as a condition of membership, States accept the jurisdiction of the courts. There is no opt-out. This is unlike any other regional human rights instrument or any part of international law, but it is put forward in this thesis as the main reason why Europe has been the most successful implementer of human rights. Thus it seems appropriate to suggest that the supranationality of European law, the compulsory ratification of instruments and the jurisdiction of the

¹⁷⁰ Eleftheriadis P, 'Aspects of European constitutionalism' (n 138) 35.

¹⁷¹ Mangold AK (n 153) 229.

¹⁷² Gardbaum S (n 119) 762.

¹⁷³ *ibid* 761.

¹⁷⁴ *ibid*.

courts, serves as an example to international human rights law and law-making global institutions, which would be much more successful implementers of human rights by recognising the constitutionalism of their law. If the constitutionalism of certain international treaties is recognised then the role of organisations and systems that must be in place is equally important and a role for judicial review will be reserved as guardians of the rule of law and above politics.¹⁷⁵

Viewing international human rights law as supranational constitutional law establishes a human right to healthcare which has to be appropriately implemented. Ways to achieve this were discussed at the beginning of the chapter, but where there is no remedy, there is no right, and therefore such constitutional rights also have to be enforceable. This requires something different, which is why the effective nature of recourse to a court in countries with a constitutional right to healthcare was discussed in 3.2. International Courts have been widely suggested, and this thesis now turns to discussing the prospect of enforcing human rights through such a court.

6.2.3 A World Court of Human Rights

The idea of a World Court of Human Rights (WCtHR) is not new and is perhaps most associated with the work of Manfred Nowak.¹⁷⁶ However, as early as 1947 the Australian government, leaning on the well-established proposition that where there

¹⁷⁵ Klabbers J (n 81) 33.

¹⁷⁶ See for example Nowak M, 'The Need for a World Court of Human Rights' (2007) 7 Human Rights Law Review 251; see also Nowak M, and Kozma J, 'A World Court of Human Rights' (2009) Protecting Dignity: An Agenda for Human Rights - Swiss Initiative to Commemorate the 60th Anniversary of the UDHR.

is no remedy there is no right,¹⁷⁷ supported the creation of an International Court of Human Rights.¹⁷⁸ It is seen as uncontroversial that international law will be relatively ineffective without specific provisions for enforcement, with even critics of universal human rights suggesting a need to better utilise the International Court of Justice.¹⁷⁹ As mentioned in the conclusion of chapter two, Buergenthal also suggests a United Nations Court for Human Rights, but proposes much more constrained ideas, and in less detail, than Nowak's World Court. Buergenthal suggests that the court should begin by only having the jurisdiction to offer advisory opinions and not have individual standing.¹⁸⁰ His suggestion is that this court would be more likely to gain State support for its establishment and it would then be easier to widen its jurisdiction later. This may be true, but is very much more a political, Machiavellian discussion of how best to realise what is established to be the best system for implementing human rights. Such international diplomacy does not find a large space in this thesis. Eventually a 2008 report by the Panel of Eminent Persons, of which Nowak was a member, strongly recommended the creation of a fully independent, permanent World Court of Human Rights, which would make final and binding decisions on human rights violations of all duty-bearers.¹⁸¹ This idea was solidified and expanded when, a year later, a draft statute for the World Court was published.¹⁸²

¹⁷⁷ Blackstone W (n 90) 'it is a general and indisputable rule, that where there is a legal right, there is also a legal remedy, by suit or action at law, whenever that right is invaded.'; see also, *Marbury v. Madison* 5 U.S. (1 Cranch) 137 (1803) at 163; Clark DL (n 49) 220.

¹⁷⁸ Panel of Eminent Persons *Protecting Dignity: An Agenda for Human Rights* (2008) 74-5; see also Panel on Human Dignity *Protecting Dignity: An Agenda for Human Rights* (2011) 35-6.

¹⁷⁹ Brown C, 'Universal Human Rights' (n 95) 53.

¹⁸⁰ Buergenthal T, 'A Court and Two Consolidated Treaty Bodies' in Bayefsky AF (ed), *The UN Human Rights Treaty System in the 21st Century* (Kluwer Law International 2000) 301.

¹⁸¹ Panel of Eminent Persons *Protecting Dignity: An Agenda for Human Rights* (2008) 110-1.

¹⁸² Nowak M, and Kozma J (n 176).

6.2.3.1 Structure

In many ways, and this is admitted by Nowak himself, the proposed structure and organisation of the Court follows that of the European Court of Human Rights. It should consist of six committees of three judges to decide whether complaints before it are admissible; individual cases should be decided by three chambers with seven judges; and inter-State cases should be decided by a plenary court of twenty-one judges. This plenary court can also act as an appeals chamber for individual cases in exceptional circumstances.¹⁸³ There is some concern around global juristocracy in that unrepresentative international judges will be called upon to adjudicate disputes and should not rely on their conception of constitutional legitimacy from their home country, but will be required to interpret the conception from the original society, which may be impossible.¹⁸⁴ For Raz, and Rawls as seen in chapter five, because the principles governing international relations should be different from those governing an individual society as the content of the principles will differ, this cautions against external interference and scrutiny.¹⁸⁵ Once again the example of Europe can be used as this dilemma is dealt with daily. Nowak also discusses the Inter-American Court and the African Court of Human Rights but argues the model of Europe is stronger and contends that the existence of these other Courts shows that the idea of an international court is not limited to Western Europe. The only region without a regional court and also without a full regional organisation is Asia and the Pacific. Rather than see this as a disincentive to the universal nature of a human rights court, Nowak suggests this is an incentive for the WCtHR which should be inspired by the experiences of the three existing regional

¹⁸³ *ibid.*

¹⁸⁴ Möller K (n 119) 394; Peters A, 'The Merits of Global Constitutionalism' (n 92) 408.

¹⁸⁵ Raz J, 'Human Rights without Foundations' in Besson S, and Tasioulas J, (ed), *The Philosophy of International Law* (Oxford University Press 2010) 331; Freeman S, 'Distributive Justice and the Law of Peoples' in Martin R, and Reidy DA, (ed), *Rawls's Law of Peoples: A Realistic Utopia* (Blackwell Publishing 2006).

human rights courts.¹⁸⁶ If the difficulty and difference in conception of law in these Courts, especially in Europe, is so extreme then the simple strategy and important doctrine of the margin of appreciation can be used. Given the notion that a World Court would only be used after domestic remedies are exhausted, this simply requires allowing the final decision of the highest national court.¹⁸⁷ Such large differences are however, unlikely when adjudicating the minimalist universal human rights.¹⁸⁸

6.2.3.2 Establishment

One argument put forward for the need for a WCtHR has already been seen in what Nowak has called the “very essence of the rule of law”;¹⁸⁹ the idea that where there is a right, a remedy must also exist. If we are serious about rights and making them tangible guarantees as opposed to idealistic goals, then rights-holders naturally endow duties on someone or something else; in the case of international human rights, the State. If the duty-bearer does not fulfil their duty, then a remedy must be available before an independent neutral body, usually a court, which decides in a final and binding decision what reparation to provide. This reparation must also be adequate. It is not merely enough to find a violation of the right and then leave it to

¹⁸⁶ Nowak M, ‘Eight Reasons Why We Need a World Court of Human Rights’ in Alfredsson G, Grimheden J, Ramcharan BG, and Zayas A, (ed), *International Human Rights Monitoring Mechanisms: Essays in Honour of Jakob Th. Möller*, vol 35 (2nd edn, Martinus Nijhoff Publishers 2009) 701-2.

¹⁸⁷ *Handyside v United Kingdom* (5493/72) [1976] ECHR 5; Möller K (n 118) 394 – 395; See also Alston P, ‘Against a World Court for Human Rights’ (2014) 28 *Ethics and International Affairs* 197, who argues that what discussion by proponents of a World Court oversimplifies complex questions of the universality of such rights as the right to health, and argues there is definite scope for diversity in such an assessment. This point was proven in chapter one but what Alston fails to consider is the place the courts can play despite differing systems and the place for diversity. This is answered by the reasonableness test argued in the previous chapter.

¹⁸⁸ Möller K (n 119); Cohen J, ‘Minimalism About Human Rights: The Most We Can Hope For?’ (2004) 12 *Journal of Political Philosophy* 190.

¹⁸⁹ Nowak M, and Kozma J (n 176).

the State to decide what measures should be taken. Thus the mandate of the court is broad in the sense that it will be able to order enforceable reparation to ensure enjoyment of the violated right in future as well as appropriate compensation for the past.¹⁹⁰ The need for a new court can be seen because the current international legal structures have not been able to adjudicate on health, despite the International Court of Justice being asked for an Advisory Opinion by the WHO in 1993.¹⁹¹ Resolution 46/40 requested an Advisory Opinion of the Court on the legality of the use of nuclear weapons because of their effect on health. The Court's opinion came in 1996 and generally avoided the health question, stating that it did not have the jurisdiction to give such an opinion.¹⁹² Ignoring the health questions, the Court focused on self-defence and concluded by stating that they could not say whether the use of nuclear weapons would be legal or not in extreme cases and made no reference to health.¹⁹³ This disappointing opinion of the court, that they lacked jurisdiction, is further evidence that the current legal system does not offer reparation for a violation of the right to health.

Another argument put forward in favour of establishing a WCtHR is that it would not require a cumbersome and difficult amendment to the UN Charter because it has been written as a new treaty. An amendment to the Charter would require a two-thirds majority of the General Assembly as well as ratification of all the permanent members of the Security Council.¹⁹⁴ To avoid this, Nowak has written a draft statute so establishment of a World Court would not be as difficult as may be initially thought. The World Court, like the International Criminal Court, would be based on a

¹⁹⁰ *ibid*; see also Nowak M, 'Eight Reasons Why We Need a World Court of Human Rights' (n 186).

¹⁹¹ Leary VA, 'The Right to Health in International Human Rights Law' (1994) 1 *Health and Human Rights* 25, 43; see also International Court of Justice *Legality of the Threat or Use of Nuclear Weapons: Advisory Opinion of 8th July 1996* 226-67.

¹⁹² *ibid* 235.

¹⁹³ *ibid* 265-267.

¹⁹⁴ *The UN Charter*, Article 108.

new treaty, hence the draft statute, which would be adopted by the UN General Assembly after a sufficient number of States have ratified it. The Court would then take over the individual and State complaints procedure from the treaty monitoring bodies, so the Committees can focus on analysing State reports. This would help reduce the backlog of reports, allow the experts on the Committees to focus on the areas they specialise in, and allow the legal challenges to be dealt with by the judges in the Court who have the necessary specific legal expertise.¹⁹⁵

6.2.3.3 *Recourse to the Court*

Much like the ECtHR, individual complaints can be heard, which is important as without this there is limited justification for creating such a court.¹⁹⁶ This idea can be contentious on a global level with questions as to whether the State or individual people are the subjects of international law. Tesón argues that traditionally, international law focuses on the rights and duties of States and does not recognise the important status of the individual.¹⁹⁷ However I do not believe the two have to be mutually exclusive, and I agree with Brown that individuals possess the right to bring a claim against their State, which in turn is also a subject to international law which establishes the State obligation.¹⁹⁸ However, modern cosmopolitanism, based on the work of Kant, led to the emergence of human rights as the basis of international

¹⁹⁵ Nowak M, and Kozma J (n 176); see also Nowak M, 'The Need for a World Court of Human Rights' (n 176) 255-6; see also Nowak M, 'Eight Reasons Why We Need a World Court of Human Rights' (n 186) 703-4; see also Scheinin M, 'Towards a World Court of Human Rights' (2009) *Protecting Dignity: An Agenda for Human Rights - Swiss Initiative to Commemorate the 60th Anniversary of the UDHR*, 23.

¹⁹⁶ Trechsel S, 'A World Court for Human Rights?' (2004) 1 *Northwestern Journal of International Human Rights*.

¹⁹⁷ Tesón FR, 'The Kantian Theory of International Law' (1992) 92 *Columbia Law Review* 53.

¹⁹⁸ Brown C, *International Relations Theory: New Normative Approaches* (Harvester Wheatsheaf 1992) 102.

law and rights to which all individuals can claim.¹⁹⁹ Human rights led to changes in the subjects of international law, with human rights being viewed distinctly as individual rights and not, as was exclusively the case for international law, as rights for the State.²⁰⁰ Daniele Archibugi argues that this modern cosmopolitanism acknowledges universal human rights that must be protected by States, as well as the “creation of a mandatory core of rights which individuals may claim, as well as duties *vis-à-vis* global institutions.”²⁰¹ Rights in the first instance ought to relate to issues that go beyond national borders, and in turn these create duties on world citizens to allow global institutions to replace national institutions temporarily where needed.²⁰² This is similar to Brown suggesting that the State and individuals are not mutually exclusive in being subjects of international law.²⁰³ The relationship between the State and the individual is one of the principal characteristics of modern human rights.²⁰⁴ The position of children within this system is argued by George Kent, who articulates MacCormick’s philosophical ideas discussed in chapter two; the progressive change from dependency and need of protection to autonomy and capacity.²⁰⁵ Kent considers the priority is to help a child become responsible for themselves, allowing them to mature, which is the responsibility of society. If this is not possible then it becomes the responsibility of the local community, then local government, national government, and finally the international community as seen in chapters four and five where children are bestowed the principles and should be

¹⁹⁹ Pink R, 'Child Rights, Right to Water and Sanitation, and Human Security' (2012) 14 Health and Human Rights 1, 2.

²⁰⁰ *ibid* 8.

²⁰¹ Archibugi D, 'Principles of Cosmopolitan Democracy' in Archibugi D, Held D, and Köhler M, (ed), *Re-imagining Political Community: Studies in Cosmopolitan Democracy* (Stanford University Press 1998) 216-217.

²⁰² *ibid* 217.

²⁰³ Brown C, *International Relations Theory* (n 198) 102.

²⁰⁴ Mann J and others (n 105) 10.

²⁰⁵ Kent G, *Children in the International Political Economy* (International Political Economy Series, Palgrave Macmillan 1995) 5-6; see also MacCormick N, 'Children's Rights: a Test-Case for Theories of Right' in MacCormick N (ed), *Legal Right and Social Democracy: Essays in Legal and Political Philosophy* (Clarendon Press 1984).

given equal opportunities in life, and this is not limited to a small society but instead applied globally.²⁰⁶

To the idea of exhausting national remedies, before recourse to the World Court of Human Rights, it is argued in this thesis, should ideally be added an expectation that all regional remedies would be exhausted as well,²⁰⁷ so recourse to the World Court of Human Rights would not come immediately after failure in the national Supreme Court. This is the first of three recommended changes to Nowak's work in this thesis, to add in what Trechsel calls the 'Pyramid Model', to ensure uniform interpretation of human rights using the codification of international covenants creating a World Court that would act as an ultimate court of appeals.²⁰⁸ However, for Trechsel this would only apply to those rights that are in the European Convention, thus if the complaint is of a right not guaranteed by the ECHR then direct recourse to the World Court may not be admissible. This would be the case for the right to health for example. Yet the international law that is given constitutional law status should be seen as the minimum, so therefore no region or State may fall below, so it should be expected that either Europe creates a new Convention including the ESC rights not currently protected, or that the ECtHR is granted the jurisdiction to adjudicate upon international human rights law for its member States. This pyramid model helps to show the expanding nature of the rights as they filter down the systems from global, to regional, and then to national. Any regional system of human rights protection, and any regional court, must abide by the more minimal rights and jurisprudence established at the global level.²⁰⁹ Whether to take this further and add detail is left at regional discretion. The same

²⁰⁶ Kent G, *Children in the International Political Economy* (n 205) 5-6; see also Pink R (n 199) 2.

²⁰⁷ Trechsel S (n 196).

²⁰⁸ *ibid*, it is important to point out that Trechsel is merely exploring the possibility of a World Court and what it may look like, however does not believe it is possible or desirable at the present moment.

²⁰⁹ Möller K (n 119).

applies nationally after regional interpretation. In a similar way to Europe, discretion is often left to national authorities and courts to decide precisely how to balance and implement the rights that must be protected.²¹⁰ Some form of national discretion will always be expected. In addition to all of this, Nowak and Kozma propose that the UN High Commissioner for Human Rights supervise the execution of the judgments and that requests to the Human Rights or the Security Council can be made to take the necessary measures and ensure compliance of court decisions.²¹¹ One final main point to highlight about the idea of a WCtHR is that an opt-in was suggested originally, or an alternative that all treaties are subject to the jurisdiction of the court upon ratification but States can enter reservations to opt-out of its jurisdiction. These ideas have some major flaws in repeating problems already seen in international law and ignore the positive lesson of compulsory jurisdiction.

6.2.3.4 Jurisdiction and Adjudication: Differences from Europe

One key difference between the European Court of Human Rights and the proposed World Court of Human Rights is that the World Court will be expected to adjudicate on all UN treaties and conventions, or at least those ratified by the countries party to the case in Nowak's proposal, as opposed to just the one convention as in the European Court of Human Rights. This difference to Europe creates two further distinctions for the World Court: the lack of compulsory ratification, and the

²¹⁰ Fenwick H, 'Clashing Rights, the Welfare of the Child and the Human Rights Act' (2004) 67 *The Modern Law Review* 889, 911 discussing the balance between articles 8 and 10 in the ECHR and the discretion left to nations to establish the appropriate balance within their country.

²¹¹ Nowak M, and Kozma J (n 176) emphasis in original; Alston rightly points to a potential flaw with this mechanism that in actual fact, the permanent members of the Council would be immune unless they impose any punishment upon themselves. This shows that the Court is not a panacea and will require further help to enforce its rulings which is why further changes are discussed below. Alston P (n 187).

proposed adjudication of economic, social, and cultural rights such as a child's right to healthcare. In Europe, part of the requirement of becoming a member of the Council of Europe is the ratification of the European Convention on Human Rights, within which the recognition of jurisdiction of the ECtHR is also a requirement.²¹² Thus every individual within a country in Europe has possible recourse to the ECtHR. The example of the United States removing itself from the jurisdiction and participation of the International Criminal Court and not being party to the Inter-American Court of Human Rights, serves to show the difficulties in allowing a country to choose to accept jurisdiction or not. It is argued that Nuremberg offered brief hope of a minimum binding international law that could be adjudicated beyond sovereignty but was never realised.²¹³ Compulsory jurisdiction should be sought given the aim of better enforcement and implementation of human rights. This is a second change to Nowak's work recommended here, as a free opt-in seen across the rest of the international law treaties, would be likely to render the court powerless with a very small number of State's ratifying the treaty. Yet, it is acknowledged that compulsory ratification as part of UN membership in a similar way to that seen in Europe, whilst ideal and strongly recommended, could lead to extreme difficulties in establishing the World Court in the first place.

The final, and third difference to Nowak's work and between the ECtHR and the WCtHR is the question of adjudicating ESC rights. Nowak suggests that having a WCtHR that fulfils this function will show sceptics that such rights can be justiciable and adjudicated in an appropriate way,²¹⁴ yet this has been taken further in this thesis by actually establishing the appropriate jurisprudence for such a court. As shown in chapter three, it is possible to adjudicate ESC rights but there is danger in

²¹² *European Convention on Human Rights* (1950) Section II.

²¹³ D'Souza C (n 109) 2.

²¹⁴ Nowak M, 'Eight Reasons Why We Need a World Court of Human Rights' (n 186) 704; see also Trechsel S (n 196) who is one of the sceptics that believes it does not make much sense to have a court that adjudicates on certain rights, including the right to health.

doing so and it is suggested here that the proposed framework for adjudication must be followed by the World Court. Extensions of rights to extreme levels as seen in India will lead to countries not respecting the jurisprudence of the court and probably removing themselves from its jurisdiction. Blanket calls for increased spending to secure rights will lead to a poor judicial system where those with the funds to access courts gain protection of the rights and countries are forced to spend money they might not have, as seen in Brazil in section 3.1.2. An appropriate reasonableness test should be carried out, considering the resource constraints of the government and the reasonableness of any policies connected to the right in question, regardless of political slants. However, differing from South Africa slightly, it seems that part of this reasonableness test, indeed the first step of reasonableness, is the proposed minimum core of the right. Thus, if, for example, as argued earlier in this chapter, the minimum core for the right to health costs US\$40 per person per year, then availability of such funds can be analysed by a World Court. If a Global Health Fund, or GRD, is set up to provide the money that can ensure a minimum core, then failure to achieve this may well be considered unreasonable by the World Court and orders to the State could be made for change. The onus of proof would shift onto the government of a State against which a complaint is brought to prove its resource constraints, and if the international assistance is available then a World Court and the Human Rights Council can force governments to access these funds and use them for their intended purpose.

Interpreting a constitution however requires careful management, as seen in chapter three, especially with ESC rights and the right to healthcare. Thus the framework proposed in the last chapter should be followed by the World Court of Human Rights which should be established and structured in a similar way to the European Court of Human Rights. As Möller has argued, following the same

standards of review is not contentious and indeed is part of the point of international human rights law:

There is . . . nothing suspicious about the fact that . . . national constitutional courts and international human rights courts apply the same standards of review. The international mechanisms for the protection of human rights will only kick in when something has gone wrong at the national level. . . . Thus, there is no deep problem here. The point of international human rights law is *to police the boundaries of a state's sovereignty*.²¹⁵

So it is argued that a World Court should follow the same standards as national and regional courts, such as the presumption of unreasonableness and applying the minimum core, and when it is found that these are violated and the State can offer no legitimate defence based on resource constraints for example, then the argument of State sovereignty is removed and international actors have authority to intervene. Compulsory jurisdiction of the World Court to all members of the UN, in a similar way to that seen in Europe, has not been proposed in the draft statute, but it is contended here (along with the pyramid model and the use of the proposed framework) that this would be an effective way of enforcement and learning from the mistakes of the ICJ which does not have compulsory jurisdiction.²¹⁶ This idea corresponds and aligns with further changes, discussed below, especially to the structure of the UN and the treaty instruments, again often using Europe as an example.

6.2.4 Further Changes to the United Nations

²¹⁵ Möller K (n 119) 399.

²¹⁶ Fassbender B (n 88) 575.

Peter Singer has suggested some extensive changes to the United Nations in his focus to prevent crimes against humanity and such atrocities as genocide.²¹⁷ His two main proposals are: to provide the UN with greater military force so as to exercise a duty to intervene, and to move the structure of the UN to a more democratic idea of sovereignty to justify such interventions. Others have alternatively suggested that whilst there should be a move towards a more democratic world parliament, it would not require military force as it would have in the past, because of the move towards world constitutionalism and the aid of modern technologies to support this movement.²¹⁸ Within such suggestions more would need to be done to encompass ESC rights such as the right to healthcare; searching for ways to better ensure this right and enforce human rights law does not require a strong global military. Singer's suggestions on reforming the UN Security Council do highlight the focus of power in the UN and the inability to put pressure on the P5²¹⁹ countries to realise human rights. It might be expected that this would not be needed as the members of the Security Council would not violate human rights as wealthy and powerful countries that can easily afford to protect the human rights they have a large say in drafting. However, we know this is not the case, at least with respect to the United States and the right to healthcare, as well as other rights such as not to be tortured.²²⁰ Thus, the members of the Security Council cannot be perceived as model adherents to all international human rights law, so such a focus of power and inability to pressure them to observe the rights seems unwarranted. The Security Council consists of 15 members, with 5 permanent members which are: the United States, the United Kingdom, France, Russia and China. The other

²¹⁷ Singer P, *One World: the ethics of globalization* (Second edn, Yale University Press 2004) 144-149.

²¹⁸ Davis T, 'Towards A Conceptual Framework To Evaluate World Parliament Proposals' in D'Souza A, and D'Souza C, (ed), *World Constitutionalism* (Cambridge Publishing Group 2007) 144-145.

²¹⁹ This is a common term for the five permanent members of the UN Security Council.

²²⁰ Nowak M, 'Beyond the Senate Report: Torture Never "Works" the Way Torturers Tell You It Does' *The Guardian* (April 3, 2014).

10 members are elected by the General Assembly for two year terms. If any of the 5 permanent members disagree with proposals by the Council, then nothing will go ahead because each of those members have a veto, and there is no option of a veto override. Singer finds major flaws with this system.²²¹ Initially it was intended that the veto would be a very exceptional device, however it is clear that this is no longer the case.²²² The permanent members are based on the powers that emerged post Second World War and today it seems irrational to have no permanent members from the Southern Hemisphere. At the very least the addition of Brazil and India has been argued for,²²³ as well as perhaps some countries from the world's largest continent, Africa. This change however, may face legal difficulties if certain elements, especially the UN Charter, are to be considered constitutional law, as this means it is difficult to amend and any changes must not impede with the purpose of the Charter. Therefore any changes or additions that may impede the Security Council's ability to secure peace will not be allowed.²²⁴

Singer also proposes removing the veto with the requirement for a special majority such as two-thirds or three-quarters.²²⁵ This reconstituted Security Council reduces the power of the select few slightly, and increases the chances of intervention when it is necessary, whilst maintaining a powerful Security Council that can act and enforce international law. One problem with recourse to the Security Council was considered in the 1997 General Comment by the CESCR in which the impact of economic sanctions on ESC rights was addressed.²²⁶ The Committee encouraged the Security Council to strongly consider the impact of sanctions if they are not

²²¹ Singer P (n 217) 145.

²²² Fassbender B (n 88) 608.

²²³ Reisman WM (n 125) 96.

²²⁴ Fassbender B (n 88) 606.

²²⁵ Singer P (n 217) 145.

²²⁶ Committee on Economic, Social and Cultural Rights *General Comment No. 8 - the Relationship between Economic Sanctions and Respect for Economic, Social and Cultural Rights* 1997 UN doc E/C.12/1997/8 (hereafter General Comment 8).

carefully targeted, and highlights that oftentimes it is the people that suffer because leaders will pass on any economic loss.²²⁷ Thus the unintended outcome²²⁸ of strong sanctions on States that deny human rights can be further deprivation of those rights, hence General Comment 8 and the call for the Security Council to be careful and consider the impact of its decisions.²²⁹ Political realism may mean that such changes as proposed above could never happen, especially as it is difficult to see how action could be taken if some of the world's superpowers are in opposition, thus they practically have a veto regardless. It should still be seen as a non-ideal situation and an exercise of might if this occurs.²³⁰ Reisman argues that the current situation does meet the reality principle in a number of key ways.²³¹ Firstly, the permanent members do roughly represent the distribution of power globally and so any agreement means action can be undertaken and thus making it more than a verbal exercise. Secondly, the veto stops the UN being a casualty in a confrontation. This stops the organisation confronting one of the major powers which prevents it being damaged. Thirdly, Reisman highlights that there is a possibility of a 'functional veto' by the other members of the council to ensure that the P5 do not act solely in their own interests. This itself all seems a romanticised version of a Security Council which does not unanimously agree and where action is only achieved when the P3 agree and Russia and China abstain.²³²

The second proposal by Singer is to move the UN to a more democratic structure so as to better justify potential interventions. Here, once again the example of the

²²⁷ Craven M (n 29) 73-74.

²²⁸ Merton R K, 'The Unanticipated Consequences of Purposive Social Action' (1936) 1 American Sociological Review 6, 894.

²²⁹ General Comment 8; see also Craven M (n 29) 73-74.

²³⁰ Singer P (n 217) 146.

²³¹ Reisman WM (n 125) 98.

²³² Indeed initially it was considered that an abstention by a country on the Security Council would be considered a veto, however overtime this changed and it was considered tacit agreement.

European Union is used.²³³ Singer proposes a directly elected assembly, much like the European Parliament, which he argues comes with other benefits such as minimum standards for admission.²³⁴ Singer suggests a halfway mechanism because it is important to have inclusiveness with the United Nations, which is one of its strongest assets. Equally it may not be legally possible to bring in any actions of expulsion because of the principles of universality and sovereign equality which entitle every peaceful State to membership of the UN.²³⁵ Additionally there is a potential problem of withdrawal or expulsion from the UN by the power of the purse of the State. If the State in question is a major contributor, the US for example, then withholding its contribution will cause more harm than good and persuade others against such a course of action.²³⁶ This is a major dilemma facing international organisations and human rights enforcement as they must attempt to act independently of member States and impose human rights, yet at the same time they need State consent in order to do so. Singer proposes the current system of one State, one member is disproportional considering such differences in population and so recommends elected delegates proportionate to population in democratic countries, and one member to the assembly in undemocratic countries.²³⁷ This has the importance of retaining inclusiveness and changing the General Assembly to be more democratic and thus justify greater action and intervention. However, I do not believe this goes far enough to ensure ESC rights and abidance of international human rights law. Singer mentions the minimum standards for admission to the European Union and ensuring the basic minimum of human rights. Gardbaum above mentions that compulsory jurisdiction of a Court as a condition of membership remains limited to the European Court of Human Rights. And Nowak

²³³ Singer P (n 217) 147.

²³⁴ *ibid.*

²³⁵ Fassbender B (n 88) 610; see *The UN Charter*, Article 4, 1.

²³⁶ Klabbers J (n 81) 41-42.

²³⁷ Singer P (n 217) 147-8.

has proposed at length, and drafted a statute for, a World Court of Human Rights. Thus, it seems possible and logical to demand more from members of the United Nations, at least those who will have more than one delegate in the General Assembly and thus more influence. As a minimum condition it should be expected that all UN treaties and conventions are ratified by UN member States, and this includes a new UN Convention, Treaty or Statute for the establishment of a World Court of Human Rights. This compulsory ratification is again using the model of Europe and the European Convention on Human Rights. Thus it becomes a requirement for States to ratify the CRC and recognise a child's right to healthcare. This will have the largest effect on the United States as one of the few countries in the world yet to ratify the CRC, and if refusal is continued, various penalties and sanctions could be established. The new model of the Security Council would mean that economic sanctions for failure to realise such basic human rights in a country where resources are not a concern are possible. Such sanctions or fines or directives, could also be ordered by the World Court if a case is brought before them regarding the number of children in the US without health insurance.

One common objection to these ideas which needs to be refuted is the idea of Western Hegemony. Most of the proposals use the EU as a model of its success in enforcing human rights, however there is surely a difference between the EU and the UN, and the European community and the global community from which we cannot easily escape.²³⁸ The Chairman of the UN Working Group drafting the CRC stated that we should not try to escape from traditions and diversity of values but that the rights must be established within their context.²³⁹ The greater cultural diversity across the globe as opposed to within Europe has led to claims that, for

²³⁸ Burman E, 'Local, Global or Globalized?: Child Development and International Child Rights Legislation' (1996) 3 *Childhood* 45, 45-46.

²³⁹ Lopatka A, 'The Rights of the Child Are Universal: The Perspective of the UN Convention on the Rights of the Child' in Freeman M, and Veerman P, (ed), *The Ideologies of Children's Rights*, vol 23 (Martinus Nijhoff Publishers 1992) 48; see also Burman E (n 234) 60.

example, different values, such as 'Asian values' mean that universality and the consequent denial of diversity is harmful and unsatisfactory.²⁴⁰ However Amartya Sen refutes this idea stating that "Asian values that are invoked to justify authoritarianism are not especially Asian in any significant sense."²⁴¹ The traditions of countries such as India and China have been said not to differ much from Western countries anyway, and it has been argued that such criticism is not against the international human rights instruments themselves, but against any idea of outside influence.²⁴² However, as rightly pointed out, the U.S. also fears such impact which is one of the reasons for its poor ratification record of the human rights instruments.²⁴³ Widdows also purports a fundamental humanity arguing that such distinctions misrepresent the traditions of ethics, divides the world inappropriately and forgets we are all human.²⁴⁴

It must also be considered that international human rights law is established from the Universal Declaration which was drafted with the representation of China, India, Iran, Lebanon and the Philippines.²⁴⁵ Van Bueren also makes this point highlighting the contributions made by many developing and Eastern States, especially in the international law on children's rights.²⁴⁶ The drafters were drawn from all over the world representing many different regions, religions, cultures and legal practices

²⁴⁰ Kirby M, 'Health Care and Global Justice' (2011) 7 International Journal of Law in Context 273, 281.

²⁴¹ Sen A, 'Human Rights and Asian Values' (Sixteenth Morgenthau Lecture on Ethics and Foreign Policy Carnegie Council on Ethics and International Affairs, 1997) 30.

²⁴² Wolff J (n 56) 25.

²⁴³ *ibid* 26.

²⁴⁴ Widdows H, 'Western and Eastern Principles and Globalised Bioethics.' (2011) 3 Asian Bioethics Review 14; for a counter argument see Brown C, 'Universal Human Rights' (n 95), where he argues that the differences within cultures undermines natural law accounts of what it is to be human, which is the only basis for establishing human rights. As discussed above, Pogge accepts this but sees it as no block to establishing consensus; Pogge T, *Realizing Rawls* (Cornell University Press 1989) 270-1.

²⁴⁵ Morsink J, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (University of Pennsylvania Press 1999) 4.

²⁴⁶ Van Bueren G, *The International Law on the Rights of the Child* (Kluwer Law International, Martinus Nijhoff Publishers 1998) xix.

and interpretations, yet a consensus was still reached.²⁴⁷ Thus, Asian values and a lack of universality in human rights would seem to be undermined, but concern over using a European model may still arise. However, it should be noted that this is merely a model of implementation and not of the rights in question. The rights enforced by a new global model will still be those established via global mechanisms, and it has also been suggested that the right to health, with its physical nature, goes beyond such diversity and is seen as identical everywhere.²⁴⁸ In terms of suggestions that universal human rights are problematic because of cultural diversity and because of their principles being Western; it is the fundamental, underlying, yet overlapping consensus that these human rights have tried to reach to take them beyond problems of cultural diversity, much like Rawls' theory of justice.²⁴⁹ It could be argued that in order to find this lowest common denominator, the content would be so minimal and lacking in any specificity, as to be meaningless and too thin for the issues international human rights law seeks to resolve.²⁵⁰ I contend however that the principles of justice are "devoid of real content",²⁵¹ yet an obligation and right to healthcare has been found within them. Green agrees with such value and cultural holism, arguing that differences cannot possibly conflict and are interconnected and mutually supporting. Despite differing cultural values there will be some holism where there is no conflict and it is through this scope that we should evaluate rights and Convention jurisprudence.²⁵² This commonality and

²⁴⁷ Kasper J, and Wise PH, 'The Relevance of the United Nations Convention on the Rights of the Child for United States Domestic Policy: Welfare Reform and Children in Immigrant Families' (2001) 5 Health and Human Rights 64, 69.

²⁴⁸ Lopatka A (n 239) 49; for disagreement arguing that the psychology of a child, influenced itself by culture, influences the physical, see Burman E (n 238).

²⁴⁹ Pogge T, *Realizing Rawls* (n 244) 270-1.

²⁵⁰ Brown C, 'Universal Human Rights' (n 95) 46, 56.

²⁵¹ *ibid.*

²⁵² Green A, 'A philosophical taxonomy of European human rights law' (2012) 1 European Human Rights Law Review 71; Green also argues that establishing rights must focus on the correlative duty and as such must be very specific. Thus he does not see a right to healthcare as such, but to the more specific provisions that one might expect to arise from such a right, such as a right that the State adopt a reasonable healthcare policy. I contend that rights naturally become more specific when they are implemented and enforced by the

overlapping consensus within the international texts has been highlighted previously by Tomuschat who argues that such texts define the realm of common agreement.²⁵³

Additionally, given the international treaties that have been agreed upon, especially the near 100% ratification of the CRC, it seems that cultural differences have not been a barrier to achieving an underlying consensus.²⁵⁴ This idea and my opinion on enforcing human rights has been perfectly expressed by Kent and the argument is worth quoting in full:

One way to deal with the problem of cultural relativism is to say that the international law of human rights is about universal minimum human rights. International conventions on human rights should be based on universally recognized rights. Of course this means that international law can codify only the 'lowest common denominator' of rights that are widely accepted. Individual countries should be free to make more stringent specifications of human rights, and to vary among themselves, provided that they recognize and work within that baseline universal minimum. This understanding implies that international human rights law would cover only a narrow base of issues. But the fact that the law focuses on only a few major issues, and is codified without exceptions, could make it much more powerful.²⁵⁵

Enforcing universal human rights cannot be seen as cultural imperialism that will suppress societies and their way of life. Rather ensuring these human rights is more likely to secure fundamental opportunities for all people. Intervention by the UN might be seen as a step too far, but in certain circumstances, intervention will help

courts, and also with General Comments that Committees release to clarify their expectations. Therefore I circumvent the moral question of rights necessarily being more specific than those which are established in international law as I believe enough information is already available, at least for the global level, and regions and States should be allowed and expected to go further, but not below the global line.

²⁵³ Tomuschat C (n 127) 237-8.

²⁵⁴ Johnson D, 'Cultural and Regional Pluralism in the Drafting of the UN Convention on the Rights of the Child' in Freeman M, and Veerman P, (ed), *The Ideologies of Children's Rights*, vol 23 (Martinus Nijhoff Publishers 1992) 113; see also Burman E (n 238) 52 who argues the consensus has been reached at the cost of any specificity.

²⁵⁵ Kent G, 'Little Foreign Bodies: International Dimensions of Child Prostitution' in Freeman M, and Veerman P, (ed), *The Ideologies of Children's Rights*, vol 23 (Martinus Nijhoff Publishers 1992) 339.

prevent a way of life that is not an element of a distinctive culture worth protecting, such as female genital mutilation,²⁵⁶ or a culture of privatisation, smaller government and negative rights, such as that in the United States, that allowed 6.6 million children to live without any health insurance in 2012.²⁵⁷

6.3 Concluding Remarks

The aim of this chapter has been to extend previous ideas of a global theory, bringing a global difference principle and framework of adjudication of ESC rights into practice. Therefore, the ideas and practical changes were proposed based on this and began by exploring ideas of a global difference and what this could look like in practice. Philosophical ideas about the need for economic redistribution were further explored, in order to establish a firm ground of justification, based on the concept that the current economic order does not practice anything representing a global difference principle and in fact, actively causes harm to the poorer nations in the world, as the current order originates from the world's most powerful countries that subsequently benefit the most. After this considering the arguments for economic redistribution, practical ways of how this might be done were explored. Here, two findings were of central importance; the world could quite easily afford the extra money required to realise a minimum core of a child's right to healthcare; and the global financial institutions are failing to adhere to their international legal obligations to help protect and ensure a child's right to healthcare.

After this, the idea of enforcing the right was undertaken, bringing in the concept of international human rights law as part of the international constitution, and

²⁵⁶ Singer P (n 217) 141.

²⁵⁷ DeNavas-Walt C, Proctor BD, and Smith JC *Income, Poverty, and Health Insurance Coverage in the United States: 2012* Washington DC.: U.S. Census Bureau (Current Population Reports, 2013) 29.

discussing the emerging area of global constitutionalism. Comparing human rights treaties and the international conventions to constitutional law, justifies the use of the judicial framework based on jurisprudence from courts that have adjudicated a codified right to healthcare. This brought discussion to the possibility of a World Court of Human Rights, to ensure that such judicial enforcement could occur on a global scale. Here, the work of Manfred Nowak was largely followed, modified by three amendments and recommendations, notably that: the international law opt-in may not work as this is one of the current reasons there is weak enforcement; there should be a push for a full pyramid model, exhausting regional remedies before reaching the World Court; and that the framework argued for in the previous chapter of this thesis should be followed in order to avoid problematic jurisprudence that governments will not accept. This final chapter has brought together themes developed throughout the thesis to make lots of ideas and proposals for change that may help address the problem of children's lack of access to even basic levels of medical care.

Conclusion

A child is born a blank slate. Their future is unknown. We cannot be certain what their hopes and dreams will be. What is certain however is that the opportunities whereby they may fulfil those hopes and dreams, rests in the hands of others. Are they born in a society that allows them to strive for whatever it is they want to be? Are they born in a country that gives every child the same chance? Are they born in a world with healthcare, so that genetic predisposition and misfortune do not decide what a child can aspire to become?

The spark that spawned this thesis was the question ‘why does America not seem to be such a society that allowed children those chances because it was a society without universal healthcare?’ Unfortunately, it still is. That initial question also had a second part: what could be done on a global level to enforce the provision of healthcare services? Once again the unfortunate answer is nothing; at least not right now. The connection between the importance of healthcare to children and their opportunities required a philosophical foundation; something that was also thought could support the cogent arguments justifying a child’s right to healthcare. Equally, as it was seen how anaemic and insipid international law can be, research had to consider the issue of enforcement and implementation. It was hoped in this way that persuasion and enforcement of the law could be achieved. What was sacrificed by heading in these different directions was a singular focus on any one particular topic. It is argued that what focus there is, is sufficient, but it cannot be claimed that this thesis has the depth in any one area that an entire thesis on that topic would have. All of the areas discussed in this work could easily be a full thesis on their own. This is perhaps the greatest strength, and also weakness of this work. It was never intended to be so interdisciplinary, but in pursuing the search to the foundation and justification of this right, the work quickly turned from a purely legal

analysis of a child's right to healthcare in international law, towards a search for a just world, in which access to healthcare services is one important part.

Healthcare is considered a basic human right, appearing in many national constitutions as well as universally agreed upon documents. If these words were put into practice then we would have a just world where every child had access to good quality, basic healthcare. In order to explore if this is the case, this thesis was split into two parts; firstly, to explore the problem by analysing healthcare systems, international law and the adjudication of the rights; and secondly, to address the problems established in the first part, by searching for convincing moral arguments for a State and global obligation to provide the right, and then recommending specific changes to practical enforce it. Thus Part A began by analysing the current situation around a child's right to healthcare and unfortunately showed that the ideal is not being realised.

Chapter one highlighted the problem. Using health indicators to support a brief overview of the state of children's healthcare in certain countries, clear problems emerged. Three developing countries were chosen as examples where the right to healthcare exists within their written constitutions, yet without the political will to push for drastic change, such a codified right remains words on paper, just like the international human right to health. The three developed countries that were considered, show that different healthcare systems can achieve appropriate levels of children's health protection, and thus we can accept a margin of appreciation in the delivery of this right. However, it is also shown that the frequent omission of wealthy countries from healthcare analysis is unwarranted when we consider the poor state of healthcare in the richest country in the world, the United States. Here the healthcare policies of the past cannot be excused by reference to any margin of appreciation or claims to independent sovereignty, as without resource constraints these policies have left 6.6 million children without health insurance. There is

however a glimmer of hope in the Affordable Care Act which could ensure coverage to a further 26 million Americans by 2017. Even this does not go far enough. Thus, healthcare is far from a perfect institution with many countries failing through resource constraints or lack of political will. Therefore chapter one very clearly set out the need for discussion on a child's right to healthcare, the obligations of the State, and the enforcement strategies required to realise it this right.

In chapter two the thesis began to look at the current legal position of a child's right to healthcare in international law in an attempt to explore real, practical problems and set later discussion of ways to realise and enforce the obligations in context. It was seen in chapter two how weak the current international legal structure is, with a self-reporting system and an opt-in to human rights conventions. The notable exception is Europe which has compulsory ratification of the European Convention on Human Rights as a condition of membership of the Council, and strong implementation of rights due to the courts. It is widely acknowledged that Europe is the most successful implementor of human rights in the world, and as such it is often used as a template from which lessons can be learnt as to how to better implement human rights globally.

Because of the impact of the courts in Europe, consideration of adjudicating the right to healthcare was undertaken in chapter three. The justiciability of economic, social and cultural rights generally has been a heavily debated topic, and the argument of this thesis is that the courts have an important role in implementing such rights. Drawing on examples of the developing countries from chapter one that have the right to healthcare within their written constitutions as a model, because this is similar to the codification of the right in international law, it was shown how lessons can be learnt from each jurisdiction; even if it is what not to do.

The thesis then moved on to Part B to address the problems seen in Part A, and began trying to answer the question of the moral underpinnings of such a right and whether the State is required to ensure it in the hope of providing the most convincing arguments for those individuals who are so ardently against the right and State obligation. Why should we care about the ill-health of strangers? Why should the State be obligated to provide basic healthcare to each child? There are many ways to answer such questions and in chapter four, one possible answer was proposed drawing on a minimal theory of justice by John Rawls. Chapter four explained the theory, which simply argues that we can only assess whether our world is just if we can remove all prejudices and knowledge of ourselves that are morally arbitrary, such as intelligence, gender, religion and so on. This hypothetical exercise is designed to place individuals behind the veil of ignorance. This thick veil, or original position, denies all morally arbitrary knowledge in a paragon of what Rawls calls 'pure procedural justice', the outcome will be fair and just no matter what it is. If we challenge individuals to place themselves behind the veil of ignorance, and then decide on principles to govern society once the veil is lifted, those principles will be the basis of a just society.

The three most important outcomes of the theory for this thesis are: the clear application of the principles to children; the equality of opportunity principle; and the difference principle. Very little has been written about Rawls' theory and children and what little literature there is, is often mistaken. Although in Rawls' theory children cannot be in the original position themselves, children are included because they will be considered as subsequent generations despite Rawls' apparent omission. It seems fair to say that the contractors will agree to bestow the principles upon children to protect them and allow them to become rational adults. The contractors will be unsure what their society will be like once the veil is lifted, they will be naturally conservative and minimalist in the principles they set down.

Therefore those they do set down are very basic and will arise from an overlapping consensus of all contractors; as such they will be universal as well. They will be principles which it is logical to want more of than less, and one of these is opportunity. Thus the principle of fair equality of opportunity will be established. Finally wealth, which is on the same list of things it is always logical to want more of than less, informs the difference principle. This is because the contractors will be naturally risk averse as they could find themselves in the position of the worst off when the veil is lifted. Therefore they will set down that inequalities in wealth are only acceptable as long as the worst off are better off than they otherwise would have been; the difference principle. The logical extension of Rawls' theory to include healthcare is provided by Daniels who argues the fair equality of opportunity necessitates healthcare. Ill-health clearly impedes one's opportunities in life. Therefore health and healthcare are a matter of justice. It follows therefore, that any society that can be considered just must ensure basic healthcare services.

Having considered Rawls' theory, the thesis then explored how this can be extended in order to show how it applies globally, so it can inform the international legal obligation to ensure children have basic healthcare and its enforcement. This was done in chapter five, mostly through the work of Thomas Pogge. Pogge extends Rawls' theory by arguing for a global difference principle and highlighting the current injustice in the global economic order. By its very nature *A Theory of Justice* can apply globally because there is no restriction on the size of the society Rawls places in the original position. For Pogge, the focus is on a global difference principle and the unjust economic order which leaves many countries with the inability to realise a child's right to healthcare. To this globalised idea, possible judicial enforcement is added, and it is seen from the lessons learned earlier in chapter three, that courts must be careful not to overstep in to budgetary decisions and policy making in areas that are considered the prerogative of a democratic

government. Instead the main role of the courts is oversight and ensuring reasonableness of the governments policy which, it is argued, includes use of a minimum core as a presumption of unreasonableness. This framework is important if there is to be any universal oversight and adjudication of the right to healthcare, which as seen in chapter two may be an important tool in enforcing human rights, but needs to be managed appropriately by using the above framework so that judicial decisions are respected and implemented.

Finally, in chapter six the various conclusions drawn in the preceding chapters were brought together and carried forward in proposing more specific changes that need to be made to the international legal order. There is undeniably a child's right to healthcare in any just world through the extension of Rawls' opportunity principle. Extending the theory globally demands a global difference principle, which also serves to help those countries that cannot afford even a minimum core to healthcare. It is also shown that the world can afford to provide the funds required if the global economic order was adjusted as necessary. The proposals for change of the enforcement strategies for human rights focus on viewing the core human rights treaties as an international constitution and subsequently their adjudication by the courts. This culminated in one of the main concluding proposals of this thesis; to establish a World Court of Human Rights. As long as there is appropriate adjudication and a presumption of unreasonableness if a basic minimum is not being achieved, such a court with universal oversight could become a valuable part of the human rights enforcement strategy and limit the ability of States to simply ignore their human rights obligations. Various other possible changes are discussed at the end of chapter six as further ways to implement the necessary change in the United Nations and the international legal community. These include a more democratic General Assembly with greater powers and more permanent members of the Security Council with the removal of the veto. Such changes have been

suggested many times because international law is at a pivotal point. If it continues to be inept and meaningless and if the superpowers simply ignore their basic obligations, then the UN may dwindle into obscurity and ineffectiveness and be a repeat of the League of Nations. However, increased awareness and globalisation shows promise that international law is being taken more seriously and the world can head towards a monist hierarchy. The recent failure of the Millennium Development Goals has focused the attention of the world on how much is still needed to be done. This focus may be the push for change that has been needed and if the world can respond to this challenge and recent failure, something may be salvaged from the disappointment of the MDGs. Important changes are needed to realise this and the promise of human rights. It is equally important that the world does not wait and miss this vital opportunity.

Change will not come if we wait for some other person, or if we wait for some other time. We are the ones we've been waiting for. We are the change that we seek.

- President Barack Obama

We have the ideas. We have the capacity. We must now change to avoid international legal obscurity. Martin Luther King once said that “a right delayed is a right denied.” We cannot pretend there is a right to healthcare in international law if we are not willing to change now. Change in the face of American obstinacy. Change leading to equality of opportunity. We must have the courage to change.

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Appendix 1

A NEW DAWN FOR HUMAN RIGHTS IN FIJI? LEARNING FROM COMPARATIVE LESSONS

Dominic O'Brien and Sue Farran*

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Abstract: New beginnings offer new opportunities but also present new challenges. The restoration of democracy in Fiji in 2014 was accompanied by a new and far reaching Constitution, which, among other things, promises much in the context of social, economic and cultural rights. These rights, which have sometimes been described as soft or 'third generation' rights, give rise to resource demands, and in developing and least developed countries, governments may struggle to deliver on promises, or if they seek to do so may encounter certain difficulties. In this article we look across the globe at comparative examples of how different countries have met their international and national obligations to give effect to the right to health and healthcare, especially for children, and use this comparative exercise to consider the options open to Fiji in considering how to fulfil the expectations raised by an ambitious new Constitution.

Keywords: *Human Rights, Right to Healthcare, Children, Comparative Law, Fiji, India, South Africa, Brazil, Columbia*

I. Introduction

Following what appears to have been a peaceful election in September 2014 Fiji is back on the road to democracy after several years of government by decree following a military coup in 2006. Part of this process includes a new constitution. This promises to be far reaching and in particular includes extensive human rights provisions in Chapter Two. The rights with which this paper is concerned are those which broadly fall under economic, social and cultural rights – which go far beyond Fiji's current international obligations,¹ notably the right to health, especially the rights of children to health care. This paper locates those rights within the international rights context and within the comparative perspective of a child's right to health and healthcare elsewhere, drawing on the examples of India, South Africa, Brazil and Columbia. This comparison is made in order to examine the challenges that may confront Fiji in delivering on this right and to identify the approaches which have succeeded and those which have created as many problems as they have solved. While it is recognised that in many respects the situation in this Pacific island state is unique, nevertheless it is hoped that with virtually nothing in the way of local or regional precedent to guide it, experiences from elsewhere may serve as useful lessons for the newly elected government to consider.

This article first briefly introduces the reader to those aspects of Fiji which are significant for the focus of the paper. It then examines the new rights provisions in the Constitution, locating these against the broader international background of human rights and in particular the right to health care. Express provision for the right to health care is relatively rare in national bills of rights, nevertheless there are comparators elsewhere, and it is to these that attention is turned in order to explore how the right has been given effect and what consequences this has had. The article concludes by considering what can be learnt from these comparative experiences and whether these lessons might be useful to Fiji in meeting the expectations raised by its new constitution.

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¹ Fiji has not ratified the ICESRC.

II. Background

Young people are a significant factor when considering health provision in Fiji. A mid 2013 estimate suggested that those aged 0-14 accounted for 28.2% of the total population of 859,200,² with an average population growth rate estimated at 0.8%, and a crude birth rate of 19.1 per 1,000. Infant mortality is 13.1 per 1,000 (based on 2010 data). In 2008 it was reported that Fiji had made good progress towards MDGs and in terms of human development, but it was also noted that less than half the population had access to basic health infra-structure such as clean water and sanitation.³ Poverty and hardship in rural and urban squatter areas was particularly noted, with estimates of over 25% of the country's population living below the basic needs poverty threshold.⁴

Although the 2008 report referred to above was reasonably positive, Fiji's own Ministry of Health has pointed out in its Strategic Plan 2011-2015,⁵ that targets in MDGs 4, 5 and 6 will not be met by 2015,⁶ and that among the contributory reasons for this are the 'cost of health services to allow (the) poor to take advantage of available health facilities'.⁷ Similarly, while infant mortality has declined, MDG 4 will not be met unless it declines by a further 57% over five years (a tall order when it has already taken twenty years to decline by 23%).⁸

² The SPC *Pacific Island Populations – Estimates and projections of demographic indicators* < <http://www.spc.int/sdd/>> accessed 6 March 2015.

³ SPC *Fiji Islands Country Profile 2008* <<http://www.spc.int/sppu/images/COUNTRYPROFILES/fiji%20country%20profile%20final.pdf>> accessed 9 November 2014.

⁴ SPC *Fiji Islands Country Profile 2008* (n 3) 2.

⁵ Ministry of Health, 'Shaping Fiji's Health: Strategic Plan 2011-2015' <http://www.wpro.who.int/health_services/fiji_nationalhealthplan.pdf> accessed 9 November 2014.

⁶ MDG 4: reduce child mortality; MDG 5: improve maternal health; MDG 6: combat HIV/AIDS, malaria and other diseases. United Nations 'Millennium Development Goals and Beyond 2015' <un.org>

⁷ Ministry of Health (Fiji) *Shaping Fiji's Health* (n 5) 8.

⁸ The Australian Government Report on Health in Fiji suggest that while Fiji is on-track to achieve the reduction of child mortality it is not on track as regards infant mortality, under-five mortality or maternal mortality and states that 'a more concerted effort is necessary to

Of particular relevance to this article are the Fiji Ministry of Health's own stated aims which are to: 'Improved child health and reduced child morbidity and mortality'. There are eight objectives under this aim:

1. Develop and disseminate a child health policy and strategy
2. Strengthen emergency neonatal care at all paediatric units
3. Improve child health assessment and strengthen child health support services in antenatal, perinatal and postnatal period
4. To ensure over 95% for birth dose for hepatitis B to be given within first 24 hours and introduce the rotavirus and pneumococcal vaccine into the child health immunisation schedule.
5. Maintain all hospitals as baby friendly
6. Reduce the incidence rates of Low Birth Weight babies by 5%.
7. Ensure 95% of 5-15 year olds are screened for Rheumatic Heart Disease and that 80% of those positive for RHD managed via public health and clinical services
8. Strengthen Neonatal Intensive Care Unit (NICU) and Paediatric Intensive Care Unit.⁹

Although children are not the only focus of this Strategic Plan, the significance of the plan is that this is clear evidence of Fiji's commitment to child health care and that these objectives establish priorities which will inform, as will be seen below, the incremental achievement of certain rights for children. This is, moreover not only the wishful thinking of policy makers but ties in directly with new constitutional provisions in Fiji regarding the right to healthcare, which in turn can be located against a much broader international rights context.

III. The legal framework

ensure better health outcomes for the whole population'. Australian Aid proposes to focus its efforts on strengthening primary health care to reduce mortality and illness among mothers, babies and young children. <aid.dfat.gov.au> accessed 8 November 2014.

⁹ SPC *Fiji Country Profile* (n 3) 21-22.

The international context

The international legal framework for the right to health especially for children can be found inclusively in the Constitution of the World Health Organization, the Universal Declaration of Human Rights, and the International Covenant on Economic, Social and Cultural Rights (ICESCR), and specifically in the United Nations Convention on the Rights of the Child (UNCRC).¹⁰ The UNCRC also has an optional protocol, its third, which will allow children to make direct complaints to the Committee. This opened for signature in February 2012, and entered into force on 14th April 2014, three months after Costa Rica became the 10th country to ratify it.¹¹ As of November 2014 only 14 countries have ratified this optional protocol, and Fiji is not one of these. However, the main advantage and difference of the CRC over the ICESCR and other Committees, is that the UNCRC itself has been ratified by 193 out of a possible 196 countries, including Fiji.¹²

The UNCRC is overseen by the Committee on the Rights of the Child (CCRC) which is a non-judicial body with clear limits to its jurisdiction. It works with other bodies of the UN, particularly the Economic and Social Council and the General Assembly, which may result in technical assistance being provided to certain countries based on their reports.¹³ There are differing views about the efficacy of the UNCRC. It has been suggested, for

¹⁰ Constitution of the World Health Organization (1946) preamble; this is after defining health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', for in depth discussion as to why this very broad definition may not be appropriate see; D Callahan, 'The WHO Definition of "Health"' (1973) 1 The Hastings Center Studies 77; See also, N. Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008) 37; D. Da Costa Leite Borges, 'Making Sense Of Human Rights In The Context of European Union Health-Care Policy: Individualist and communitarian views' (2011) 7 International Journal of Law in Context 335, 337; The Universal Declaration of Human Rights (1948), Article 25; International Covenant on Economic, Social and Cultural Rights (1966), Article 12; Convention on the Rights of the Child (1989) Article 24; see also art.5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (CERD); arts 11.1(f) and 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW).

¹¹ Committee on the Rights of the Child: Monitoring children's rights available from, <https://treaties.un.org/pages/viewdetails.aspx?src=treaty&mtdsg_no=iv-11-d&chapter=4&lang=en>

¹² UN Treaty Collection

<https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en> accessed 19 November 2014.

¹³ R.K.M. Smith, *Textbook on International Human Rights* (6th edn, Oxford University Press 2014) 47.

example, that the reporting system lacks teeth,¹⁴ as there is little that can be done in the way of legal sanctions should a state choose to ignore the concluding observations of the Committee,¹⁵ and it can be argued that this has led to the lackadaisical attitude of many countries towards the reporting process.¹⁶ Claims of 'soft' enforcement are supported by the fact that the Convention does not state any consequences for failure to report or non-compliance with the Convention, and as such it has been suggested that the rights are more idealistic goals and aspirations than tangible guarantees with legal effect.¹⁷ Additionally, because of a lack of an institutional set-up to claim the rights on behalf of a particular child, there is little scope to make demands on the state to meet its rights' obligations.¹⁸ Contrastingly, it has equally been suggested that the reporting procedure is a positive exercise that leads to open dialogue and inclusiveness that can be an honest appraisal and assist by highlighting areas where help is needed.

The formal, international acknowledgement of a child's right to healthcare is promising but is far from a guarantee of promotion and implementation. The near universal ratification of the CRC may be meaningless, if, as Tomás highlights:

there is no effective supervision over and enforcement of the way in which each country promotes and guarantees the CRC, besides the periodical writing of reports for the International Committee on the Rights of the Child, it is foreseeable that in a decade's time, we

¹⁴ M. Freeman, 'The Future of Children's Rights' (2000) 14 *Children and Society* 277, 290.

¹⁵ M. Freeman, 'The Limits of Children's Rights' in M. Freeman and P. Veerman (eds), *The Ideologies of Children's Rights*, (Martinus Nijhoff 1997) 71-80; see also E. Burman, 'Local, Global or Globalized? Child development and international child rights legislation' (1996) 3 *Childhood* 45, 50; J. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini and H.V. Fineberg, 'Health and Human Rights' (1994) 1 *Health and Human Rights* 7, 10.

¹⁶ E. Bates, 'The United Kingdom and the International Covenant on Economic, Social and Cultural Rights' in M. Baderin, and R. McCorquodale (eds), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007) 267-268.

¹⁷ Burman (n 15) 50; see also Freeman (n 15) 71-80; M. Freeman, 'Laws, Conventions and Rights' in M. Freeman (ed), *The Moral Status of Children: Essays on the Rights of the Child* (Martinus Nijhoff 1997) 47-62; Bates (n 16).

¹⁸ O. O'Neill, 'Children's Rights and Children's Lives' (1988) 98 (3) *Ethics* 460; see also C. Brown, 'Universal Human Rights: A critique' (1997) 1 *The International Journal of Human Rights* 41, 53.

will still be able to say only that it is the most ratified international document; the rights to protection, to provision and to participation are universally recognised for children but the problem resides in the way they are, or are not, put into practice.¹⁹

Freeman has suggested that if the Committee is to remain the fulcrum of enforcement, it should be permanent and given more powers,²⁰ and Navi Pillay, the UN High Commissioner for Human Rights, 2008-2014, admitted that economic, social and cultural rights lack 'appropriate enforcement mechanisms at the international level'.²¹ It is very much the case therefore, that responsibility for giving effect to children's rights and in particular the right to healthcare rests on national governments,²² and in this respect Fiji promises much.

Fiji's laws

The domestic legal framework of Fiji has at its apex, in principle at least although this has not been the case in recent years owing to its abrogation, the written constitution. The Constitution which is considered here, and which was signed into law in 2013, is Fiji's fourth constitution since its first in 1970 when it became independent. Subsequent constitutions followed in 1990 and 1997. The new constitution is not the first to include a bill of rights but goes considerably further than previous constitutions in its provisions for social and economic rights, at the cost, some might say, of cultural rights.²³

The Constitution opens with a statement of values (s1) the fourth of which is 'equality for all and care for the less fortunate based on the values

¹⁹ C. Tomás, 'Childhood and Rights: Reflections on the UN Convention on the Rights of the Child'(2008) 2(2) *Childhoods Today*: an online journal for childhood studies available at <<http://www.childhoodstoday.org/article.php?id=19>> accessed 19 November 2014.

²⁰ Freeman (n 14) 290.

²¹ N. Pillay, 'Human Rights in United Nations Action: norms, institutions and leadership' (2009) 9 *European Human Rights Law Review* 1, 2.

²² C.E. Easley, S.P. Marks and R.E. Morgan Jr, 'The Challenge and Place of International Human Rights in Public Health' (2001) 91 *American Journal of Public Health* 1922.

²³ This is because there is virtually no reference to indigenous rights for native Fijians and indeed there is emphasis in the Constitution that the people of Fiji are inclusive and holistic and not distinguishable on ethnic grounds.

inherent in this section and in the Bill of Rights contained in Chapter 2'. In setting out the supremacy of the Constitution the next section (s2(3)) states that: 'The obligations imposed by this Constitution *must* be fulfilled ...' (emphasis added). At the outset therefore we are looking at mandatory obligations imposed on the state and a strong emphasis on the Bill of Rights. This is found in Chapter Two and s6(1) stipulates that 'This Chapter binds Parliament, the judiciary, the executive branch of government at all levels, and every person performing the functions of any public office'. It is therefore implied that private individuals are not bound by the obligations of the Bill of Rights although there is the possibility that this may be modified through the process of interpretation and application. The scope of these rights obligations are influenced by a number of considerations. Firstly s6(6) states that they are not absolute but may be 'limited by limitations expressly set out or authorised in relation to a particular right or freedom in this Chapter, or as limited by provisions set out elsewhere in this Constitution'.

Secondly, in providing for the interpretation of this Chapter on the Bill of Rights, s7(1)(b) states that a court or tribunal or 'other authority' 'may, if relevant, consider international and foreign law, applicable to the protection of the rights and freedoms in this Chapter'. This point is important for our purposes as it makes it possible to bring into the interpretation equation the international statements of rights referred to above, including of course the UNCRC. Thirdly, the interpretation section goes on to provide in s7(5) that in giving effect to the rights enumerated a court has to consider not only the 'context and consequences of the law' but also the 'impact upon individuals or groups of individuals'. As will be seen in some of the comparative examples, this consideration in the context of healthcare can be significant as decisions regarding the allocation of resources, especially for health care or access to health services, can have a number of consequences for individuals or groups of individuals.

The Chapter then details an extensive list of rights. The ones we are most interested in here are found in s35, the right to health, and s38 rights of children, but these also have to be read with s26 which provides for the right to equality and freedom from discrimination.

Turning first to the right to health, there are three main provisions: firstly, that the obligation of the state to provide health care and secure to each individual the right to health is subject to progressive realization subject to available resources; secondly, a person cannot be denied emergency medical treatment; and thirdly, that if the State claims it lacks resources for giving effect to the right to health and healthcare the state must demonstrate that it lacks the necessary resources.

There appears at first sight therefore to be a minimum core obligation imposed on the state to provide health care,²⁴ although the possibility of modifying this absolute compliance has already been flagged up above, under s6(6). At the same time however, if a strict or even literal interpretation is adopted, the state may need to be very clear as to why it is or is not putting resources into particular forms of health care. As comparative case law demonstrates, a court is not bound to accept the justifications of the state. Moreover when it comes to the health care of children, not only might international rights considerations come into play but also the rights of children are strengthened through the dedication of s38 to the rights of children, particularly s38(1)(b) which states that every child has the right 'to basic nutrition, clothing, shelter, sanitation and health care', and the section concludes 'The best interests of a child are the primary consideration in every matter concerning the child' (s38(2)).

The scope of the state to justify not resourcing or under-resourcing certain health care may be further limited by the s26 provisions against discrimination. Direct or indirect discrimination is prohibited on an extensive range of grounds under s26(3)(a) including 'economic or social or health status, disability, age, ... or pregnancy', and s26(4) states that 'Accordingly, neither a law nor an administrative action taken under a law may directly or indirectly impose a disability or restriction on any person on a prohibited ground'. This clearly limits prohibited discrimination to actions based on

²⁴ See S. Liebenberg, 'The Value of Human Dignity in Interpreting Socio-Economic Rights' (2005) 21 South African Journal of Human Rights 1, 22-26; see also, K.G. Young 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 The Yale Law Journal of International Law 113,159, where it is argued that use of the minimum core will shift the onus of proof on to the state. It is interesting that Fiji is appears to have incorporated this academic concept within its Constitution.

written laws and would, for example, exclude policy guidelines, internal memorandums of practice and so on, all of which are more likely to be informing resource distribution across health care services than laws. However, s26(7) is not so limited and states 'A person shall not discriminate directly or indirectly against any other person on any of the prohibited grounds'. Notionally therefore a hospital administrator or health board which makes the decision not to finance the treatment of drug addicts, for example, could be guilty of discrimination on the grounds of health status. They may, however escape liability under the next section which provides a 'wriggle out' route as it states 'Treating one person differently from another on any of the grounds prescribed under subsection (3) is discrimination, unless it can be established that the difference in treatment *is reasonable in the circumstances*' (emphasis added). The allocation of resources might be seen as reasonable in the circumstances, but as will be seen from the comparative analysis, this threshold of reasonableness is not without problems.

The new Constitution is therefore a brave attempt to ensure that Fiji complies with its international obligations, strives to meet MDGs and meets its own development goals and objectives including those relating to health. At the same time it is recognised that there are limited resources to achieve these aims and that progress may have to be incremental.

Choices will have to be made. But how easy is this? The same rights have been recognised in other parts of the developing world, in different ways and approached via different strategies. It is to these experiences that we now turn in order to consider if lessons can be learned from these comparative examples.

IV. Delivering on the right to health in India, Brazil, South Africa and Columbia

India

India is one of the best known examples of a country that has established a justiciable right to health and, unlike the situation now possible in Fiji, has done so without the right being within the enforceable sections of the Constitution. The right to health is in Part IV of the Indian Constitution, known

as the Directive Principles of State Policy (DPSP) – somewhat comparable to the ‘values’ statement in the Fiji Constitution. Article 37 states this Part ‘shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws.’²⁵ Despite this clear limitation it is the case of *Keshavananda Bharati v State of Kerala*²⁶ that is considered to have opened the floodgates for the Indian judiciary to establish an enforceable right to health.²⁷ Here the Indian Supreme Court restricted the right of the government to amend the Constitution, ruling that the government could not amend the ‘basic structure or essential features of the constitution.’²⁸ The court also discussed within this context the DPSP, recognising their importance to the enforceable fundamental rights and their complementary nature.²⁹ In this case one Judge said: ‘In building up a just social order it is sometimes imperative that the fundamental rights should be subordinated to the directive principles’,³⁰ which led to the belief that they were complementary with ‘neither part being superior to the other.’³¹ It is suggested that after this case in 1973 and following the state of emergency declared between 1975 and 1977, the perception of the judiciary in India changed concerning ‘its role in the working of the Constitution.’³² Between 1975 and 1977, large scale rights violations occurred across India and the post-emergency period led to political realignment and a weak government

²⁵ Government of India, Ministry of Law and Justice. The Constitution of India, modified up to 1st December 2007.

²⁶ (1973) 4 SCC 225.

²⁷ I. Byrne, *Making the Right to Health a Reality: Legal Strategies for Effective Implementation* (Commonwealth Law Conference 2005) available from <<http://www.escri-net.org/docs/i/401242>> accessed 6 March 2015; see also S. Muralidhar, ‘Justiciability of ESC Rights – the Indian Experience’, Circle of Rights Economic, Social and Cultural Rights Activism: A Training Resource International Human Rights Internship Program 2000 <<http://www1.umn.edu/humanrts/edumat/IHRIP/circle/justiciability.htm#30t>> accessed 19 November 2014.

²⁸ *Keshavananda Bharati v State of Kerala* (1973) 4 SCC 225 at para 1615.

²⁹ *Keshavananda Bharati v State of Kerala* (1973) 4 SCC 225 at para 1707; see also Muralidhar (n 27).

³⁰ *Keshavananda Bharati v State of Kerala* (1973) 4 SCC 225 at para 879.

³¹ *State of Kerala v N.M. Thomas* (1976) 2 SCC 310 at para 367; see also Muralidhar (n 27) and S. Muralidhar, ‘Economic, Social and Cultural Rights: An Indian Response to the Justiciability Debate’ in Y. Ghai and J. Cottrell (eds), *Economic, Social and Cultural Rights in Practice: The Role of Judges in Implementing Economic, Social and Cultural Rights* (Interights 2004) 24-25.

³² Muralidhar (n 27).

that did not last long.³³ The judiciary stepped in and promoted the public-interest litigation (PIL) movement which, acknowledging that the majority of the population could not access the justice system, and relaxed procedural rules to the extent that it was claimed that even 'writ petitions could be submitted on a postcard.'³⁴ The post emergency period allowed the judiciary to redeem itself by becoming actively involved in the protection of those who were deprived of their most basic constitutional rights. PIL was the tool the Court used to disregard the traditional requirements of *locus standi*.³⁵ This was clearly seen in *Sunil Batra v Delhi Administration*³⁶ where a prisoner who was being tortured wrote a letter to the Supreme Court, which was taken up as a petition and the court made orders for humane treatment. Progressively the court began to expand its protection and interpretation beyond the basic rights guaranteed in the Constitution. As more destitute individuals were able to come before the courts, it was inevitable that the courts would have to decide if they were going to protect them or not.

PIL has been critical in bringing ESC rights within the scope of the judiciary,³⁷ despite the apparent non-justiciability of ESC rights in the Indian Constitution, largely because the Supreme Court took it upon itself to make some of the principles in the DPSP equivalent to the protected civil and political rights. It has done this mainly 'through the application of an expansive definition of the right to life.'³⁸

One palpable example of this expansion was seen in 1992 in *Mohini Jain v State of Karnataka*,³⁹ in which the court, in discussing the right to education, clearly accepted and established the interdependence of the fundamental rights of Part III of the Constitution, and the DPSP of Part IV. This case was concerned with the charging of capitation fees for private

³³ Ibid.

³⁴ Byrne (n 27) 16; Muralidhar (n 27).

³⁵ T.R. Andhyarujina, 'The unique judicial activism of the Supreme Court of India' (2014) 130 Law Quarterly Review 53; Muralidhar (n 27).

³⁶ 1978 4 SCC 494.

³⁷ Muralidhar (n 31) 25.

³⁸ Byrne (n 27) 16.

³⁹ (1992) 3 SCC 666.

colleges and so centred on the expense of higher education.⁴⁰ In finding the fees illegal, the Supreme Court held that '[t]he right to education flows directly from the right to life. The right to life under Article 21 and the dignity of an individual cannot be assured unless it is accompanied by the right to education.'⁴¹ The extension of the right to life was one argument used, but the court also determined the interdependence of the DPSP and fundamental rights, stating: 'The directive principles which are fundamental in the governance of the country cannot be isolated from the fundamental rights guaranteed under Part III. These principles have to be read into the fundamental rights. Both are supplementary to each other.'⁴² This argument was reiterated just a year later in a case that was brought by private colleges challenging state legislation regulating the capitation fees. In *Unni Krishnan, J. P. v State of Andhra Pradesh*,⁴³ the court went a little further in clarifying the argument that the two parts of the Constitution were interdependent. Again extending the right to life by arguing for the interdependence of rights and more particularly the importance of the right to education to the right to life, the court held that Article 41 in the DPSP informed the content of the right to life, but they were quick to assert that not every DPSP would inform what the right meant. The court decided that in this instance only Articles 41, 45 and 46 would determine the parameters of the right.⁴⁴

So the court established that the DPSP can inform the content of a right that has been found via extension of fundamental, enforceable rights in Part III of the Constitution. With this in mind the court ruled that children have a fundamental right to free education up to the age of 14, and beyond that the enjoyment of the right is subject to economic capacity. The court did briefly mention the progressive realisation of the ICESCR as an indication that this objective should be followed for children over 14, but it gave no more information as to whether a challenge by a 16 year old that their ICESCR rights were not being progressively realised would be successful or

⁴⁰ In India, capitation fees are fees that are not advertised in the prospectus, charged by an institution after admission has been accepted.

⁴¹ *Mohini Jain v State of Karnataka* (1992) 3 SCC 666, page 8.

⁴² *Mohini Jain v State of Karnataka* (1992) 3 SCC 666, page 7.

⁴³ (1993) 1 SCC 645.

⁴⁴ *Unni Krishnan, J. P. v State of Andhra Pradesh* (1993) 1 SCC 645 at paras 48-50.

justiciable.⁴⁵ The extension of the right to life to the right to education is significant because the right to health has also been included through this form of expansion.

The key case to do this is *Paschim Banga Khet Mazdoor Samity and Ors v. State of West Bengal*⁴⁶ (*Samity*). In this case a labourer by the name of Hakim Seikh fell out of a train in West Bengal suffering serious head injuries and a brain haemorrhage. He was taken to eight state medical institutions over the next 14 hours and refused access to all of them either because of a lack of beds or lack of necessary facilities for his treatment. He was eventually admitted to a private hospital which cost Rs.17,000.⁴⁷ The court was very quick to establish that the one important question it would use to decide the case was: is the non-availability of treatment a denial of a fundamental right under Article 21?⁴⁸

Paragraph 9 of the decision leaves no room for doubt that the court believed the right to health is an integral part of the right to life, and that this right had clearly been violated in these circumstances. The argument was based on reading the Constitution as envisaging a welfare state, which in turn establishes a government obligation to provide adequate medical facilities. The court held that failing the obligations envisaged by a welfare state would violate the right to life guaranteed under Article 21.⁴⁹

The court then, crucially, went beyond merely finding a violation to the right to health via the right to life and ordering redress, by proceeding to issue directions to the government on the exact facilities that should be provided. The court did this by taking into account the opinions of an Enquiry Committee appointed by the state government and listening to other experts and 'learned Counsel'⁵⁰ to make further specific orders to the state government before ruling that these orders should apply to all other states

⁴⁵ *Unni Krishnan, J. P. v. State of Andhra Pradesh* (1993) 1 SCC 645; see also J. Kothari, 'Social Rights and the Indian Constitution' (2004) 2 Law, Social Justice and Global Development Online Journal <http://www2.warwick.ac.uk/fac/soc/law/elj/lgd/2004_2/kothari> accessed 17 May 2015; Muralidhar (n 27).

⁴⁶ (1996) 4 SCC 37.

⁴⁷ *Paschim Banga Khet Mazdoor Samity and Ors v State of West Bengal* (1996) 4 SCC 37 at para 2 (*Samity*).

⁴⁸ *Samity* at para 4.

⁴⁹ *Samity* at para 9.

⁵⁰ *Samity* at para 14.

within India as well as the national government.⁵¹ The facilities which the court ordered were extensive, including a better communication set up, better ambulance services, and the upgrading of hospitals at district and sub-division level.⁵² The court admitted that such expansive direction would require financial resources but merely commented in response that constitutional obligations cannot be ignored. There was no discussion or consideration of the financial implications or a possible resource allocation prerogative of the government and it would appear that the obligation stands irrespective of any financial constraints.⁵³ All that was said was '[w]hatever is necessary for this purpose has to be done.'⁵⁴ This expansive direction is where many criticisms of the Indian Supreme Court lie. *Samity* is one example, however the court also started to get involved in ordering petrol pump sites, rules of conduct for public authorities, control of automobile emissions, parking charges and many more trifling matters that should not be considered by any court, least of all a country's Supreme Court.⁵⁵

The Indian Supreme Court has faced many criticisms of illegitimately extending its jurisdiction into areas regarded as the prerogative of a democratic government through 'overt judicial activism'.⁵⁶ Tobin has commented:

The work of the Indian Supreme Court with respect to the scope of the right to life provides a precedent for such a strong and expansive interpretative approach. In several cases the Court has pushed the boundaries of

⁵¹ *Samity* at paras 16 and 17.

⁵² *Samity* at para 15; see also. Byrne (n 27).

⁵³ J. Chowdhury, 'Judicial Adherence to a Minimum Core Approach to Socio-Economic Rights – A Comparative Perspective' (2009) Cornell Law School Inter-University Graduate Student Conference Papers, 1.

⁵⁴ *Paschim Banga Khet Mazdoor Samity and Ors v State of West Bengal* (1996) 4 SCC 37 at para 16.

⁵⁵ For a good overview of the myriad of cases the court has decided on such minor matters see T.R. Andhyarujina, 'The unique judicial activism of the Supreme Court of India' (2014) 130 *Law Quarterly Review* 53.

⁵⁶ Kothari (n 45).

the right to life beyond what would be considered reasonable in many jurisdictions.⁵⁷

The court however, has remained stoic, arguing that it is filling the void created by inadequate branches of government and that the importance of the policy decisions outweighs a strict adherence to separation of powers.⁵⁸ One of the problems with this judicial activism has been 'continued non-implementation ... undermining the court's authority.'⁵⁹ This raises questions about the legitimacy of the court and demonstrates a lack of respect for the decisions of the court. One of the main problems causing this is the structure of the court, which has multiple benches of often just two judges and hears thousands of cases, meaning it is impossible to keep track of all matters, leading to inconsistent decisions from different benches and a breakdown of the system of precedent.⁶⁰ However elsewhere it is suggested that there has been a general acquiescence by the government to such judicial activism.⁶¹ There have doubtless been some cases where the government has disagreed with the court to such an extent as to pass legislation, or the cabinet has had to assert an ordinance, so that the order of the court is rendered void.⁶²

A reaction to judicial activism in India is evident in the Judicial Appointments Commission Act (No.40 of 2014). This is in response to the judiciary seizing power from the executive to appoint judges and further illustrates the tension between the two branches in India. This dates back to 1993 when the courts reversed the position set out in the Constitution that the president, after consultation with the Chief Justice, would appoint judges to the superior courts.⁶³ This consultation was interpreted as concurrence,

⁵⁷ J. Tobin, *The Right to Health in International Law* (Oxford University Press 2011) 187.

⁵⁸ Kothari (n 45); see also Byrne (n 27).

⁵⁹ Muralidhar (n 27), see also Kothari *ibid* (n 45) and Byrne (n 27) 11.

⁶⁰ N. Robinson, 'A Quantitative Analysis of the Indian Supreme Court's Workload' (2013) 10 *Journal of Empirical Legal Studies* 570; the Supreme Court's workload continues to increase disproportionately to that of lower courts, the opposite of what may be expected and a clear indication that precedential value in decisions is being lost.

⁶¹ Andhyarujina (n 55) 65.

⁶² See, *Golak Nath v State of Punjab* 1967 2 SCR 762; *Shiv Sagar Tiwari v Union of India* 1996 6 SCC 530.

⁶³ *Supreme Court Advocate on Record Association v Union of India* (1993) 4 SCC 441.

and the Chief Justice would make their recommendations to the President, who would have limited scope to disagree. Further influence was grasped by the judiciary when the requirement of consultation was changed to requiring an 'advisory opinion' whereby the Chief Justice, together with some senior colleagues, known as a 'collegium', would recommend names to the President, who would then be bound by the decision.⁶⁴ The government reaction has been this legislation. The next step is the establishment of a national judicial commission to appoint senior judges which will remove the power solely from the courts.

Despite this constitutional tension, it is clear that India now has a justiciable right to healthcare and has made moves to enforce ESC rights through the courts using an imaginative interpretation of the right to life. The former UN Special Rapporteur on the right to health has used the *Samity* case to argue 'that there are health related rights that give rise to some immediate obligations that are not subject to resource availability.'⁶⁵ This refers to the 'essential minimum' the court ordered which is similar to the minimum core content envisioned by the Committee on ESC rights and which is immediately enforceable and beyond resources constraints. Hunt, rather more pragmatically, argues that 'if a Government of a low-income country has insufficient resources to meet its immediate health-related obligations, it is incumbent upon those in a position to assist to provide international assistance and cooperation that will enable the Government to meet its immediate obligations.'⁶⁶ This is an argument for the legal obligations of the world's most developed countries to provide more international aid and assistance and change the global economic order.⁶⁷

⁶⁴ Special Reference No. 1 of 1998, Re: (1998) 7 SCC 739.

⁶⁵ P. Hunt, 'Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled "Human Rights Council": Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (A/HRC/4/28 United Nations General Assembly ed., 2007) at para 67.

⁶⁶ *Ibid.*

⁶⁷ See for example, G. Ooms and R. Hammonds, 'Taking up Daniel's challenge: The case for global health justice' (2012) 12 Health and Human Rights 29; see also M. Craven, 'The Violence of Dispossession: Extra-Territoriality and Economic, Social, and Cultural Rights' in M. Baderin and R. McCorquodale (eds), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007) 82; see also, T. Pogge, *World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms* (2nd. Edn, Polity Press 2008); see also R. Hammonds and G. Ooms, 'World Bank Policies and the Obligation of Its Members to

India it seems provides some very mixed results. On the one hand, judicial activism may lead to unrealisable expectations and jeopardises the separation of powers which underpin democratic government. On the other hand, PIL has made the courts more accessible to those who would otherwise have been ignored and prompted widespread discussion on the fulfilment of their fundamental rights. Kirby, in defending PIL, has argued that protection is needed from 'decision-making that is wholly political'.⁶⁸ This is why we look at comparative examples of adjudication; to see what lessons Fiji needs to learn. While the right to health in Fiji is clearly distinguishable from that in India, because in the former it is an express right, the duty imposed on the judiciary (and other agents) to meet the obligations of state are not dissimilar and raise the question of how pro-active the courts are expected to be in this regard and whether the boundaries between the different branches of state may be crossed in seeking to give effect to the rights of children in particular, to health care. Similarly, it might be asked what weight might be given to the values stated in s1 of the Fiji Constitution referred to above, particularly if the intention is that these are read with the Bill of Rights, as has been argued in India.

Brazil

The example of Brazil initially appears to be more similar to the provisions of the Fiji Constitution. Brazil has an express right to health in Article 6 and more specifically Article 196 of its Constitution.⁶⁹ This subsequently led to the introduction of the *Sistema Único de Saúde* (Unified Health System), known as the SUS in 1990 as a 'universal, publicly-funded, rights-based

Respect, Protect and Fulfill the Right to Health' (2004) 8 Health and Human Rights 27; and M. Darrow, 'Human Rights Accountability of the World Bank and IMF: Possibilities and Limits of Legal Analysis' (2003) 12 Social & Legal Studies 133.

⁶⁸ M. Kirby, 'Deconstructing the law's hostility to public interest litigation' (2011) 127 Law Quarterly Review 537, 555

⁶⁹ 1988 Constitution of the Federal Republic of Brazil, translation from the original, in Portuguese, Art. 196. (*A saúde é direito de todos e dever do Estado, garantido mediante políticas sociais e econômicas que visem à redução do risco de doença e de outros agravos e ao acesso universal e igualitário às ações e serviços para sua promoção, proteção e recuperação*); see M.M. Prado, 'The Debatable Role of Courts in Brazil's Health Care System: Does Litigation Harm or Help?' (2013) 41 Journal of Law, Medicine and Ethics 124, 135 footnote 2.

system'.⁷⁰ There can be little doubt that this has had a considerable impact on the health indicators of Brazil and has been considered an outstanding success.⁷¹ There has also been successful litigation on the right to healthcare in Brazil so it may be thought to be an excellent example for other countries as well as demonstrating how obligations incurred under international law can be given domestic effect. Moreover, and particularly relevant to Fiji, Brazil has also established a priority for a child's right to healthcare, accepting the increased vulnerability of children and the need to ensure that their rights are not subordinated. Indeed the Superior Court of Justice has stated that it is a constitutional norm that children's rights have absolute priority most especially with a right to healthcare.⁷²

This shows promise for the prioritisation of healthcare for children and the positive attitude of the court in achieving this. Brazil however, is not without some major problems. One of the problems of the SUS is the inequities in access to health care services. The poor have much less access to the care they need than those who are more wealthy, and this problem, far from being rectified by the courts, is exemplified and exacerbated by the nature of Brazil's healthcare litigation.⁷³ Ferraz explains:

[T]here is instead a high concentration of right-to-health litigation in the richest states, cities, and districts of Brazil. ... The explanation for this high concentration of litigation in developed states, cities, and districts is hardly surprising: access to courts and lawyers is beyond the means and reach of most poor Brazilians.⁷⁴

⁷⁰ A. Cornwall and A. Shankland, 'Engaging citizens: Lessons from building Brazil's national health system' (2008) 66 *Social Science & Medicine* 2173.

⁷¹ World Health Organization, 'Flawed but fair: Brazil's health system reaches out to the poor' (2008) 86 *Bulletin of the World Health Organization* 248.

⁷² A. Nolan, 'The Child's Right to Health and the Courts' in J. Harrington and M. Stuttford (eds), *Global Health and Human Rights: Legal and philosophical perspectives* (Routledge 2010) 146.

⁷³ O.L.M. Ferraz, 'The Right to Health in the Courts of Brazil: Worsening Health Inequities?' (2009) 11 *Health and Human Rights* 33; see also, Prado (n 69).

⁷⁴ O.L.M. Ferraz, 'Harming the Poor Through Social Rights Litigation: Lessons from Brazil' (2011) 89 *Texas Law Review* 1643, 1662; see also D.M. Brinks and W. Forbath, 'Commentary: Social and Economic Rights in Latin America' (2011) 89 *Texas Law Review* 1943, 1946.

This exacerbation is partly because there is no public-interest litigation (PIL) system in Brazil compared to that found in India, meaning access to courts is more difficult and writ petitions cannot 'be submitted on a postcard'.⁷⁵ Also, because Brazil is a civil law country it does not adhere to the rule of *stare decisis* found in common law systems - and also incidentally in Fiji, meaning one court decision does not affect all subsequent cases with similar facts. Consequently many similar if not identical cases have been decided.⁷⁶ Further exacerbation is due to the jurisprudence of the courts and the specific way the courts have interpreted the right to health. The Brazilian courts have interpreted the right to health in the Constitution as a right of all individuals to have all of their health needs satisfied with the very best treatment, irrespective of cost.⁷⁷ This failure to consider the limited resources of the country is only one problematic consequence of the litigation in Brazil; another is that collective complaints are almost never heard, and so the vast majority of cases are individual and concern the provision of curative medicines to be enjoyed individually.⁷⁸ Ferraz points out that in Brazil 'the right to health is an individual entitlement to the satisfaction of one's health needs with the most advanced treatment available, irrespective of costs'.⁷⁹ Tobin agrees and adds that '[s]uch an approach is not only unsustainable because of its drain on Brazil's limited resources, but it also skews the benefits of the right to health to those who have access to the courts'.⁸⁰ The reasoning of the courts in accepting such arguments has been called 'syllogistic reasoning'⁸¹ because they follow the clear pattern needed for a syllogism. The argument is in essence: the Constitution guarantees a right to health for everyone; this individual has a medical need requiring certain treatment; therefore he/she is entitled to that treatment. It is a very simplistic

⁷⁵ Byrne (n 27) 16; Muralidhar (n 27).

⁷⁶ Ferraz (n 74) 1656. Interestingly, none of the common law countries in South America have recognised a right to health in their constitutions, which is suggested to be due to the influence of the US Constitution, which contains no ESC rights, see V.A. Leary, 'The Right to Health in International Human Rights Law' (1994) 1 Health and Human Rights 25, 34.

⁷⁷ Ferraz (n 73); see also Prado (n 69); Tobin (n 57) 208.

⁷⁸ Ferraz (n 73) 35.

⁷⁹ Ibid, 34.

⁸⁰ Tobin (n 57) 208.

⁸¹ Prado (n 69) 130.

argument and it is said that 'all that a claimant must do to win his or her case under this interpretation is to prove that he or she has an unsatisfied health need as documented by a doctor's prescription.'⁸² Thus somewhat unsurprisingly, the number of successful litigations is high, estimated at 90% in lower courts and 100% in the Supreme Court, when an individual asserts the need for a particular health service.⁸³

While the approach to the right to healthcare in Brazil is positive in so far as the right to health is guaranteed by the Constitution and is being enforced by the courts in a clear, consistent and strong way, the cost of such litigation must be considered as '[j]udges by and large do not engage in any form of substantive cost or economic impact analysis of their decisions'.⁸⁴ This litigation, in which the resource implications of the decision are not considered, is made even more problematic by a large increase in the number of cases. For example, Rio de Janeiro went from just one claim in such a case in 1991, to 2,245 in 2005, with federal courts also seeing large increases: the *Superior Tribunal de Justiça* (STJ), the second highest court in the country, went from 2 to 672 cases between 2001 and 2004.⁸⁵ Consequently, rather than enhancing the right to healthcare the combination of these factors has a negative impact because high success rates and increased litigation 'means that a significant volume of resources allocated to the health care system are used to pay for judicially mandated medication and treatment ... litigation allocates resources originally intended to treat a large number of people to an expensive (and sometimes experimental) treatment that may benefit just a small group, regardless of the relative wealth of the plaintiffs'.⁸⁶

This last point emphasises that plaintiffs are often relatively wealthy people, rarely the poorest in society despite the fact that it is the latter who may need state funded medicines the most. The outcome of all of this has

⁸² Ferraz (n 73) 35.

⁸³ Prado (n 69) 125.

⁸⁴ F.F. Hoffman and R.N.M. Bentes, 'Accountability for Social and Economic Rights in Brazil', in V. Gauri and D.M. Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press 2008) 139.

⁸⁵ Prado (n 69) 125.

⁸⁶ *Ibid*, 126.

been a sharp increase in federal spending on judicially granted medicines. Ferraz highlights that in 2008 São Paulo was ordered to spend approximately R\$400 million to purchase expensive drugs for 35,000 claimants.⁸⁷ He then goes on to highlight the extent of the problem: 'This is roughly the same level of resources that the federal Ministry of Health has recently announced will be invested in a program of vaccination against pneumococcal bacteria to cover all 3.2 million children born every year in Brazil.'⁸⁸ The overall federal spending on medicines ordered by the courts increased from R\$188,000 in 2003, to R\$26 million in just the first half of 2007.⁸⁹ With this large increase in spending being ordered as a result of most courts ruling in favour of any litigant with a prescription, it seems Ferraz is right to point out that 'It is likely that the increasing amount of resources spent to fund the health benefits granted to successful claimants ... is diverted at least in part from current or future health programs that would benefit larger and more disadvantaged groups who cannot easily access the courts to protect their interests.'⁹⁰

Thus it seems Brazil's courts are indirectly make resource allocation decisions which are more usually considered to be the prerogative of government. One way of justifying such direction and decision making by a court is that the courts interpret the constitutional provisions as providing a ring-fenced core element of undeniable healthcare rights, however, even if this was the initial thinking behind the courts' jurisprudence, persistence along this route without reflection on its impact has resulted in the government having less and less money to spend on basic health programmes. There is also the problem of how to get out of this vicious circle. Ferraz argues that the cumulative effect is likely to be retrogressive

⁸⁷ This equates to R\$11,428 per claimant able to access the court, as compared to the average spending of R\$3,189 per capita total health expenditure. Figures from Organization for Economic Co-operation and Development, *Health at a Glance 2013: OECD Indicators*, (OECD Publishing 2013) 155.

⁸⁸ Ferraz (n 73) 41.

⁸⁹ Hoffman and Bentes (n 84) 140; see also Prado (n 69) 126. This is an increase from R\$0.00103 per capita in 2003 to R\$0.1368 in the first half of 2007, the years that GDP went from US\$ 3,039.67 to US\$ 7,193.92. This relatively low per capita spending on medicines ordered by the courts shows how few people are gaining access to these medicines, despite the large percentage spending increase.

⁹⁰ Ferraz (n 73) 41.

and that it will be very hard for Brazil to change now it has started down this jurisprudential path.⁹¹ Thus Brazil's health jurisprudence exacerbates health inequities and trespasses into the role of a democratic government.

Both India and Brazil have a justiciable right to healthcare, but what has been seen so far is that finding support for the justiciability of the right to health is not the same as showing the appropriate way in which a court can adjudicate such a right. India has established this justiciable right via an expansion of the right to life, but has also done so for many other rights, using the argument that the DPSP in the Constitution should be justiciable. While this may well be a pragmatic response to inadequate and inert government, it is clearly not an ideal model to follow. In Brazil, by contrast and as in Fiji, the Constitution establishes a justiciable right to healthcare, but in Brazil it is the simplistic syllogistic reasoning of this right that leads to problems. A right in the Constitution, and then an individual having a medical need, should not necessarily require the state to provide for that need regardless of cost or broader priorities. The fact that the courts think it does, combined with individual litigation and the absence of collective complaints or class actions, lead the courts to make decisions which have considerable resource implications which not only deviate money from other programmes but also only benefit those who can afford access to court. So there is a difference between having a justiciable right to healthcare, and an appropriate way to adjudicate this right. Although Fiji does not have anywhere near the population of Brazil, development has given rise to an emerging middle class elite, and access to justice is not equal, not just because of wealth but because of education, geographical location, and a reluctance to engage in formal litigation more generally, preferring more customary means of dispute settlement.

South Africa

A more appropriate model for giving effect to the right to health can be found by looking at South Africa. The South African 1996 Constitution incorporates many ESC rights and, unlike the situation in Brazil, there have been very few

⁹¹ Ferraz (n 74).

significant cases decided by the South African courts.⁹² From the very beginning of post-apartheid South Africa there were challenges to the constitutional court's ability to adjudicate on ESC rights culminating in 'the First Certification case'.⁹³ Here the very inclusion of ESC rights within the Constitution was challenged before the Constitutional Court on the grounds that such inclusion was against the separation of powers doctrine because it would lead the court to make decisions, especially budgetary, that are the prerogative of the other branches of government. The court based its response on a well established argument: that adjudicating ESC rights is no different from adjudicating civil and political rights, in that both sets of rights can have a significant budgetary impact, and that as the justiciability of civil and political rights is not contested on this ground, neither can the justiciability of ESC rights be contested.⁹⁴ The court ruled that this did not result in a breach of the separation of powers.⁹⁵

In response to another more general argument that ESC rights are not justiciable, the court held that at the very least ESC rights can have negative protection so that they are not improperly impeded.⁹⁶ The court therefore made it very clear that ESC rights were justiciable and expressly acknowledged its own jurisdiction over such matters.⁹⁷ Berger points out that these short arguments put an end to the debate about the justiciability of ESC rights in South Africa, but the true meaning of winning this argument can only be seen in the context of considering the cases that came after such peremptory conclusions.⁹⁸

⁹² Byrne (n 27) 7.

⁹³ *Ex parte Chairperson of the Constitutional Assembly: in re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC).

⁹⁴ Tobin (n 57) 64, footnote 107; see also A.E. Yamin, 'Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care' (2008) 10 Health and Human Rights 45, 52.

⁹⁵ *Ex parte Chairperson of the Constitutional Assembly: in re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC) at para 77.

⁹⁶ *Ex parte Chairperson of the Constitutional Assembly: in re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC) at para 78.

⁹⁷ C. Ngweni, 'The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?' 2000, 5 Health and Human Rights 27; see also P.K. Sandhu, 'A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?' (2007) 95 California Law Review 1151, 1174.

⁹⁸ J. Berger, 'Litigating for Social Justice in Post-Apartheid South Africa: A Focus on Health and Education' in Gauri and Brinks (eds), (n 84) 42.

One case that applies specifically to the right to healthcare and access to medical treatment is that of *Soobramoney*⁹⁹ which came before the Constitutional Court in 1998. This was the first time the court ‘was asked to interpret the enforcement of a quintessentially socioeconomic right against the state’.¹⁰⁰ Soobramoney was a 41 year old man suffering from chronic renal failure who needed kidney dialysis to survive. He had been paying for and receiving this privately but now had exhausted his funds. Therefore he petitioned the state to provide him with the necessary medical care arguing his rights under Section 27(3) of the Constitution,¹⁰¹ the right to emergency medical treatment, and the right to life in Section 11. The state had denied Soobramoney care because it had in place a policy that only patients suffering from acute renal failure would automatically be provided with dialysis and priority after this would be given to those patients who would benefit from and were good prospects for a kidney transplant. Soobramoney was in the final stages of chronic renal failure, his condition was irreversible, and he also suffered from diabetes, heart and vascular disease, meaning he was not a candidate for a transplant and therefore did not fall within the guidelines. Only 30% of patients with chronic renal failure met the guidelines for dialysis¹⁰² and the state in its defence argued that the policy was in place because of a lack of resources.

The court ruled in favour of the state. It did not accept that chronic renal failure required emergency medical treatment saying section 27(3) envisaged sudden trauma not ongoing conditions and treatment. The court also dismissed the right to life argument stating that as there is a separate

⁹⁹ *Soobramoney v. Minister of Health (Kwazulu - Natal)* (1) SA 765 (CC).

¹⁰⁰ Ngwenya (n 97) 32; see also D.M. Davis, ‘Adjudicating the Socio-Economic Rights in the South African Constitution: Towards ‘Deference Lite’?’ (2006) 22 South African Journal on Human Rights 301, 305; Sandhu (n 97) 1176; M. Wesson, ‘Reasonableness in Retreat? The Judgment of the South African Constitutional Court in *Mazibuko v City of Johannesburg*’ (2011) 11 Human Rights Law Review 390, 393.

¹⁰¹ Section 27 of the Constitution is entitled “Health care, food, water and social security” and begins with;

Everyone has the right to have access to
health care services, including reproductive health care; . . .

The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

No one may be refused emergency medical treatment.

¹⁰² *Soobramoney v. Minister of Health (Kwazulu - Natal)* (1) SA 765 (CC) at para 26 (*Soobramoney*).

provision for the right to healthcare within the Constitution, the argument was unnecessary. In doing this, the court specifically referred to the *Samity* case of India and stated the differences in jurisprudence because of the specific provision in the South African Constitution, and highlighting that *Samity* not *Soobramoney* is precisely the type of case that would fall within the scope of Section 27(3).¹⁰³ The court stated that the arguments that should have been made by the appellant were based on sections 27(1), the right to access healthcare services and (2), the state must take action to progressively realise the right, but then went on to rule that even on these arguments the claim would not have succeeded because the healthcare guaranteed must be within the state's available resources. The court accepted the resource limits of the state, noting that it had actually over-spent on its budget,¹⁰⁴ and appreciated the 'difficult decisions to be taken at the political level in fixing the health budget',¹⁰⁵ stating the court would be slow to interfere when rational decisions were taken in good faith. Critically the court did not look at the case in the way a Brazilian court might have done; individually and regardless of cost. The case was decided more generally and it was accepted that the decision would have an impact on all patients in *Soobramoney*'s position and therefore the wider state health sector. Sachs J, a judge in the *Soobramoney* case, later argued that if all chronic illnesses and their treatments were to be emergency situations, the impact on the health system would be enormous with no funds left for many other important areas of health care.¹⁰⁶

Rather than adopt an individual needs-based right, as might be done in Brazil, the court in essence was asking itself, not whether the state could afford just one more kidney dialysis patient, but probably many more, and thus the court assessed the appropriateness of the guidelines that restricted dialysis to those with acute renal failure. The court noted how stretched the services were, before stating:

¹⁰³ *Sobramoney* at paras 15-18.

¹⁰⁴ *Soobramoney* at para 24.

¹⁰⁵ *Soobramoney* at para 29; see also Sandhu (n 97) 1176.

¹⁰⁶ A. Sachs, 'Social and Economic Rights: Can They Be Made Justiciable?' (2000) 53 Southern Methodist University Law Review 1381, 1385-1386.

It has not been suggested that these guidelines are unreasonable or that they were not applied fairly and rationally when the decision was taken by the Addington Hospital that the appellant did not qualify for dialysis.¹⁰⁷ ... If everyone in the same condition as the appellant were to be admitted the carefully tailored programme would collapse and no one would benefit from that.¹⁰⁸

Thus, whilst regrettable, there were legitimate resource constraints on the state, and the guidelines they had therefore applied because of this were found to be reasonable. The deference to the state to decide what was best given these constraints was the beginning of an important test of reasonableness which can be found throughout the South African jurisprudence on ESC rights. Berger suggests that *Soobramoney* shows that a right to healthcare 'does not impose an obligation on the state to provide everything to everyone'.¹⁰⁹ The court made this point itself acknowledging that many South Africans did not have housing, food, water or many other necessities, but the state had to manage its limited resources to do what it could.¹¹⁰

Soobramoney died two days after this ruling¹¹¹ demonstrating the difficulty associated with adjudicating ESC rights and the hardship associated with the search for appropriate jurisprudence. The court had to make this legal decision faced with the knowledge that, in many ways, a man's life was in their hands. Albie Sachs has written of the emotional nature of some of the Constitutional Courts cases, particularly describing

¹⁰⁷ *Soobramoney* at para 25.

¹⁰⁸ *Soobramoney* at para 26.

¹⁰⁹ Berger (n 98) 54.

¹¹⁰ *Soobramoney* at para 31.

¹¹¹ Sachs (n 106) 1386; see also Sandhu (n 97) 1177.

Soobramoney as a 'most painful case. The Court's decision could help prolong his life or else conduce to his early death.'¹¹²

This rather more reticent approach by the South African courts respecting the separation of powers in the context of the right to healthcare, and appreciating the wider repercussions of individual decisions has received some criticism. Forman has argued that the South African 'limited approach certainly misses opportunities for advancing the realization of the right, [but] it nonetheless has had a positive influence on national health policy,'¹¹³ and it does not appear that the jurisprudence of the courts in South Africa has been seized on as a positive model of how to give effect to such rights while being mindful of resource constraints. Nor does the South African decision inspire great hope in advancing the right to healthcare for those most in need. More significant however, has been the case of *Minister of Health v Treatment Action Campaign (TAC)*¹¹⁴ which in particular challenged this concept of 'reasonableness' in limiting or extending access to healthcare.

TAC is a powerful NGO that brought this case against the government of South Africa because of the government's policy on the ARV drug *nevirapine* which would prevent mother to child transmission of HIV. The drug was only available at a limited number of centres which focused on research because the government questioned its safety and effectiveness as well as questioning the connection between HIV and AIDS.¹¹⁵ TAC argued that this policy was in breach of Section 27(1), the right to access health care services. The government's defence was based on the need for continued research and a lack of resources to roll out the programme and provide the drug nationally. The government argued that at the sites where *nevirapine* was available, a full comprehensive programme was used including counselling and breast-milk substitution which was why the drug was so effective. It argued that it did not have the resources to roll this programme

¹¹² Sachs *ibid*, 1385; see also A. Sachs, 'The Judicial Enforcement of Socio-Economic Rights: The Grootboom Case' (2003) 56 *Current Legal Problems* 579.

¹¹³ L. Forman, 'Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy' (2005) 33 *The Journal of Law, Medicine and Ethics* 711, 715.

¹¹⁴ (2002) 5 SA 721 (CC).

¹¹⁵ Berger (n 98) 55.

out to other hospitals. Key to defeating this argument, however, was that *nevirapine* had been provided free of charge to South Africa for five years by the German manufacturers Boehringer Ingelheim and that even without the full supporting programme the drug would still save many lives.¹¹⁶ Thus it was found unreasonable for the government not to provide the drug at state hospitals and the court therefore required government 'to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV.'¹¹⁷ The court went further by ordering *nevirapine* to be made available at other state hospitals that were not research sites and allowing its use to prevent mother to child transmission of HIV.

This is perhaps as specific as the South African Court has been with regards to directing government actions in this context. Whilst the deference to government may be consistent with the doctrine of the separation of powers, Byrne argues the limited approach and lack of detail leads to problems with implementation of the courts orders.¹¹⁸

Nolan also points out the problems of the court's jurisprudence in not accepting direct and immediate obligations to ensure a child's right to healthcare:

The *TAC* decision is an example of a court displaying reluctance to require the State to do more than to achieve the progressive realisation of the child's right to health within that State's maximum resources. Indeed, in doing so, the Court arguably ignored the text and purpose underlying the particular constitutional provision setting out the child's right to health at issue in the case.¹¹⁹

¹¹⁶ *Minister of Health v Treatment Action Campaign* (2002) 5 SA 721 (CC) at para 57.

¹¹⁷ *Minister of Health v Treatment Action Campaign* (2002) 5 SA 721 (CC) at para 135.

¹¹⁸ Byrne (n 27) 10.

¹¹⁹ Nolan (n 72) 151.

Nevertheless the fact is that as a result of the ruling South Africa has made huge steps in the availability of ARV drugs and treatment. It should be pointed out however, that in the case the court focused its argument on the more general right to health protected in Section 27 and denied any direct or immediate entitlements to health care services for children under Section 28. Despite the appropriateness of the reasonableness test used by the South African Constitutional Court, a failure to ensure a basic minimum, especially for children, under the right to health and as part of the test for reasonableness, requires rather more assertive measures to be taken. Nolan argues that failure to make the right a direct claim for children risks it being meaningless but at the same time acknowledges the possibility that a direct claim might lead a flood of litigation such as that seen in Brazil.¹²⁰

The South African example suggests that a certain combination of elements may provide the right model for giving effect to ESC rights such as the right to healthcare: the codification of ESC rights in a constitution; an appropriate court judgment which considers cases with regards to collective – rather than individual, rights; and deference to government making difficult resource allocation decisions.

In these cases, and others,¹²¹ the court declined the use of a minimum core but left the possibility of using it later open. One of the main reasons for not using such a measure was the lack of institutional capacity of the court to decide on an appropriate minimum for the content of the rights in question. The ideal opportunity to add such content and demand a basic minimum arose when the court considered the case of *Mazibuko v City of Johannesburg*.¹²² In this case, dealing with the right of access to sufficient water, residents of the Phiri township, Soweto, Johannesburg argued, among other things, that the city's monthly allocation of 6 kilolitres of water per household per month was unreasonable. For the purposes of this article, this is the argument we will focus on, but there were many others in this complex

¹²⁰ Ibid, 149, footnotes omitted.

¹²¹ *The Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) at para 33; see also *Minister of Health v Treatment Action Campaign* (2002) 5 SA 721 (CC) at para 34.

¹²² 2010 (4) SA 1 (CC).

case. The plan that was in place by Johannesburg Water was based on a consumption rate of 20 kilolitres per household, with a monthly flat rate of R68. The actual consumption rate was a lot higher¹²³ and the revenue generated from Soweto because of a culture of non-payment was substantially out of proportion to the amount of water being supplied to the area. Therefore Johannesburg Water decided to overhaul the system to 'reduce unaccounted for water, to rehabilitate the water network, to reduce water demand and to improve the rate of payment.'¹²⁴ One of the most contentious parts of the complex plan was that only 6 kilolitres per household per month, or 25 litres per person per day, of water would be allocated for free and this allocation was seen as the sufficient amount required under section 27 (1) (b) of the Constitution.¹²⁵ Water in excess of this allowance would need to be paid for. The applicants argued that the allowance of free water was too low and should be 50 litres per person per day, on the grounds that this was the amount needed for a dignified life.¹²⁶ The court held that this argument must fail for the same reasons as the minimum core failed in *Grootboom* and *TAC*. The court did not have the capacity or authority to set a minimum core, and only a reasonableness test should be used in establishing whether the government has carried out its duty to progressively realise the basic necessities of life.¹²⁷ Key to the decision is the argument focusing on the basic necessities for a dignified life, not that this amount of water is the minimum needed for survival and therefore the clear minimum core content of the right. Expert evidence put forward and considered in the Supreme Court of Appeal decision used General Comment 15 on the ICESCR, evidence from an affidavit from I. H. Palmer and an article by P.H. Gleick, and focused on two possible minimums; one of which was 50 litres per person per day; the other was 42 litres per person per

¹²³ Although it was unclear how much of this was due to high consumption by households or leakage through pipes that had corroded.

¹²⁴ *City of Johannesburg v L Mazibuko* (489/08) [2009] ZASCA 20 at para 13.

¹²⁵ Wesson (n 100) 396.

¹²⁶ *Mazibuko* at para 44.

¹²⁷ *Ibid* at para 59.

day.¹²⁸ So in contrast to the previous cases, the applicants were able to produce specific international expert evidence on the minimum core content of the right to water. Unfortunately these arguments were not engaged with at all by the Constitutional Court, partly because the applicants accepted that the government provided the minimum necessary. Also the opportunity to engage more broadly with minimum core content was undermined by the applicants asking the court to define the right to water in its entirety, a demand which the court rejected completely.¹²⁹ A challenge to the minimum of 25 litres per person per day would perhaps have forced the court to engage with the studies and expert evidence and consider defining a minimum core of the right. Instead, the court maintained that it is ordinarily inappropriate for it, as an institution, to determine what steps should be taken to realise a right and precisely what that right entails.¹³⁰ Whilst it can be argued that not determining the full content of the right was correct,¹³¹ the court missed a chance to seriously debate the minimum content of the right and then challenge the government on the basis of a presumption of unreasonableness¹³² if this is not being fulfilled. Thus it is argued here that while South Africa has done well establishing the reasonableness test and adhering to the principles of the separation of powers, it has miss an opportunity to add minimum core content of constitutional rights to the doctrine of reasonableness.

Not everyone agrees of course. Humby and Grandbois argue that *Mazibuko* was the correct decision because of South Africa's limited resources to provide the amount of water needed.¹³³ In fact resources constraints can be included in consideration of a minimum core. What is required is that if a minimum core is identified and found not to be fulfilled,

¹²⁸ *City of Johannesburg v L Mazibuko* (489/08) [2009] ZASCA 20 at paras 17, 21, and 24; The Supreme Court of Appeal did set a minimum standard of 42 litres per person per day and ordered the city to reformulate it's water policy to one that was reasonable based on this interpretation of Section 27 (1) (b).

¹²⁹ *Ibid* at paras 52-56.

¹³⁰ *Mazibuko* (n 124) 61.

¹³¹ Wesson (n 100) 399.

¹³² S. Liebenberg, 'The Value of Human Dignity in Interpreting Socio-Economic Rights' (2005) 21 South African Journal of Human Rights 1.

¹³³ T. Humby and M. Grandbois, 'The Human Right to Water in South Africa and the Mazibuko Decisions' (2010) 51 Les Cahiers de Droit 521.

serious questions have to be asked of government. If non-fulfilment can be justified by a lack of resources then there is no breach of the right. Byrne does not see South Africa as a perfect model to follow and whilst accepting the fine line courts must walk, argues that South Africa and India are on opposite sides of that line, with neither being successful:

The cautious approach of the South African courts in relation to esrs [ESC rights] contrasts with the more assertive stance of their Indian brethren who over a much longer period have frequently been willing to actively intervene in policy and administrative areas usually viewed as the preserve of the executive, handing down detailed orders often with significant resource implications ... Critics of the Indian approach have pointed to the lack of cooperation it has apparently engendered in state officials requiring, on occasion, contempt of court proceedings to be initiated. However, the *TAC* case illustrates that the South African Constitutional Court cannot rely on the goodwill of officials to implement its decisions and may also have to be more proactive in monitoring and enforcement whilst continuing to walk a fine line in preserving the separation of powers.¹³⁴

Courts have a role in protecting the rights encoded in a Constitution and ensuring that these rights become tangible guarantees,¹³⁵ yet this must be done with deference and constant mindfulness that they are not the elected branch of government. The South African Constitutional Court has defended its approach in the *TAC* case arguing the jurisprudence of the court achieves an appropriate constitutional balance between the judicial, legislative and executive functions and this requires the courts to adopt ‘a

¹³⁴ Byrne (n 27) 11.

¹³⁵ Chowdhury (n 53).

restrained and focused role ... to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation.’¹³⁶ From the Fiji perspective South Africa may provide a useful example. Not only is there a focus on collective rather than individual rights, which finds some resonance in Fijian society and in the balance approach of the Fiji Constitution, but the South African court has shown itself to be mindful not only of its place in the balance of power, but also the impact decisions may have on resources. The progressive realisation of rights has been acknowledged as important in principle and in practice in both South Africa and Fiji.

Columbia

The South African failure to directly address the question of the minimum core of healthcare and direct entitlements for children can be contrasted with the example of the Colombian Constitutional Court.¹³⁷ The first of two important cases in Columbia was in 1998 and focused on children’s access to vaccines.¹³⁸ Indeed the example of Columbia is promising for children’s rights because the Colombian Constitution explicitly states in Article 44 that ‘[t]he rights of children have priority over the rights of others.’¹³⁹ Litigation on a child’s right to healthcare services was brought by the parents of 418 children who lived in impoverished areas of Bogotá. It was argued that these children were particularly vulnerable and at high risk because of their living conditions and because the parents could not afford to meet the costs of necessary vaccines. It was especially argued that failure to provide a vaccination to prevent meningitis for these children violated their constitutional rights. The Constitutional Court agreed accepting such basic care as part of the minimum content of the right to health which must be applied by the Court. As Nolan points out with reference to the case:

¹³⁶ *Minister of Health v Treatment Action Campaign* 5 SA 721 (CC) at para 38.

¹³⁷ Nolan (n 72) 151.

¹³⁸ Ibid.

¹³⁹ The Political Constitution of Colombia (1991)

In *SU-225/98*, the Court made it clear that the rights in Art 44 (including the right to health) have an essential content of immediate application that limits the discretion of the political organs and that rely on a reinforced judicial mechanism for their protection ... The Court concluded, however, that *only* the essential content of the right can be directly applied by the judge, while it is legislature which must define the full scope of the right.¹⁴⁰

In 2008 the Columbian Constitutional Court went further with a landmark decision that completely changed the country's health policy.¹⁴¹ Since the Constitution of 1991, Columbia has accepted individual claims for rights, much like Brazil, via *tutelas* (protection writs) which, similarly to the Public Interest Litigation of India, has enhanced access to courts by ensuring limited procedural requirements. As in Brazil, this lead to high levels of litigation with a similar success rate of approximately 80% of *tutelas* being granted in order to resolve the individual case before the court.¹⁴² In the 2008 case of T-760, the Constitutional Court brought together 22 *tutelas* to illustrate the structural and systemic problems in the health system that had led to the overuse of *tutelas*. Whilst also resolving these 22 cases the court called for a complete systemic transformation because government had not established a way of guaranteeing the right to health without recourse to the *tutela*.¹⁴³ In directing this transformation the court reiterated its own previously established jurisdiction on the enforcement of the right to health and importantly reiterated its jurisprudence on the minimum core obligations of the state. In Columbia there was a two-tier system of health benefits: the contributory regime (*Plan Obligatorio de Salud* or POS) for those earning twice the minimum wage, and the subsidised regime (*Plan Obligatorio de*

¹⁴⁰ Nolan (n 72) 151.

¹⁴¹ T-760/08.

¹⁴² A.E. Yamin and O. Parra-Vera, 'How do courts set health policy? The case of the Colombian Constitutional Court' (2009) 6 PLOS Medicine 2.

¹⁴³ Ibid.

Salud Subsidiado or POSS) for those earning less. POSS provides approximately half of the benefits available under POS. The benefits provided in these systems have been interpreted by the court as a minimum core. As Yamin and Parra-Vera explain:

According to the jurisprudence of the Constitutional Court, which reviews *tutela* judgments from courts throughout the country, the right to health is enforceable for plaintiffs unable to afford care ... when the health good or service at issue is included in the POS/POSS, which the Court has taken to define a minimum core content of the right to health.¹⁴⁴

In the 2008 case the court reiterated this jurisprudence but went further in calling for specific changes to the plans themselves. 'The judgment calls upon government to adopt deliberate measures to progressively realize universal coverage by 2010, and sets various compliance deadlines in 2008 and 2009.'¹⁴⁵ As part of this universal coverage, unification of the POS and POSS systems was ordered in order to remove discrepancies. It was also reaffirmed that these systems constitute the minimum core content of the right to health which is immediately enforceable. The aim behind increasing the funding and decreasing the waiting time for these minimum core services was to reduce unnecessary litigation via the *tutela*.¹⁴⁶ Significantly the court did not defer entirely to the government on the content of the right once these orders had been made. The court explicitly adopted the CESCR's minimum core and the definition of the right to health given by General Comment 14. This may be because Columbia is a state party to the Covenant, although this does not require the domestic courts of state parties to adopt the minimum core approach, even though this is encouraged. The Columbian court reiterated in its ruling the immediately enforceable nature of

¹⁴⁴ Ibid.

¹⁴⁵ Ibid.

¹⁴⁶ M.A. Olaya, 'The right to health as a fundamental and judicially enforceable right in Colombia' (2009) 10 ESR Review 16.

the minimum core in line with the VEDCR's interpretation of the right to health, whilst accepting the progressive realisation of other elements of the right to health subject to resource constraints. As Olaya has stated, 'The Court understood progressive realisation to mean "that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization"'.¹⁴⁷

Such specific orders for restructuring and the immediate implementation of a minimum core may be thought to overstep the division of powers in a democratic state and lead to the pitfalls experienced in India or most notably Brazil, but Yamin and Parra-Vera suggest the structural approach taken in Columbia might avoid these problems. They point out that 'the Court does not assume it knows best what benefits should be included under the POS/POSS, nor the precise ethical grounds for making these determinations.'¹⁴⁸ Thus while appearing to order government to make decisions in line with its international obligations under General Comment 14 the court avoids the specifics, deferring to government to decide on the detail. In doing so the Columbian example shows, in contrast to South Africa, how a minimum core content of the right to health established in international law can be called on in constitutional courts. In South Africa the court focused on a test of reasonableness: whether the policies of government were understandable given the circumstances; whereas the court in Columbia focused on ensuring that the government protected the basic minimum of the right to health, but deferred to government to decide the specific details.

V. Conclusion

In many respects Fiji appears to be going in the right direction for giving effect to a child's right to health and health care. Certainly from a comparative analysis it would seem that in order for economic, social and

¹⁴⁷ Ibid, 17.

¹⁴⁸ Yamin and Parra-Vera (n 142).

cultural rights to be justiciable – particularly the right to healthcare for children, constitutional recognition is required as a first and fundamental step. Without this there may still be provision for the right to healthcare but this may open the door to the possibility of the type of imaginative interpretation used by the Indian Supreme Court with resulting adverse consequences such as lack of respect for the court and contempt of court proceedings. Constitutional recognition or ‘codification’¹⁴⁹ should prevent or at least restrain courts from imaginative interpretation. This form of integration into the legal system is also similar to the right to health established in international treaties and conventions. Attention needs to be paid to the structure, form and content of this codification however. In India statements of general values have been elevated to modify the substantive provisions of the Constitution, while in Columbia the fact that children’s rights take priority has been usefully employed to ensure a minimum core, but may also trump other rights claims. The current provisions in the Fiji Constitution lie somewhere between these: there is a statement of underlying values, and there are specific provisions for children, as well as the right to healthcare, but there is no express order of priority. It might therefore be open to a court to establish its own order of priorities, either to give effect to particular policies or in line with international commentary – for example through the international treaty reporting process. Alternatively the government, through its control of budgets might dictate priorities. This might however mean that effectively the government (not necessarily by legislation) encroaches on the powers of the court to interpret legislation, thereby putting at risk the doctrine of the separation of powers, which, while it may be more difficult to achieve in small island developing states, is nevertheless a principle which underpins democratic governance. Consideration of the Columbia experience might suggest a compromise between respect for the distinct branches of government and the duty of the court to hold the government to account through ruling on a minimum core but leaving it to government to work out the details.

¹⁴⁹ Byrne (n 27).

The comparative analysis also suggests that an established jurisprudence which shows some deference to the principle that the power to allocate resources is usually the preserve of government is required, so as to avoid the problems seen in Brazil. Consideration regarding the relationship between resource allocation and rights is evidenced in the Fiji Constitution. What is absent is a national or even regional body of jurisprudence for courts to draw on in respect to the determination of ESC rights. As seen from the case-law considered above, these constitutional cases are complex and demand astute legal minds and well-versed human rights and constitutional lawyers. While these are not absent in the Pacific region they are not prolific and, without access to legal aid funds, are likely to be expensive. In looking to relevant common law precedents there is always the danger that reference is made to jurisprudence drawn from countries with vastly different resources for and demands on, their healthcare systems – such as Australia and New Zealand, not only because these are closest to hand and share a common law heritage, but also because of the influence of judges from these countries in the Courts of Appeal of the region. Ideally any overseas judges ruling on such questions would familiarise themselves with the health needs, priorities and the economic realities of the country.

Linked to this question of interpretation of the rights of children to healthcare, is the question of what challenges to ‘reasonableness’ or ‘progressive achievement’ might be raised? Given that Fiji is only just emerging from nearly a decade of non-democratic government – during which most of the existing judiciary were either dismissed or replaced, it may be unlikely that the exercise of the power of the government to decide on what is or is not reasonable or what steps should be taken for progressive achievement, will be challenged by a pro-active court. Similarly, although there are examples of group action in Fiji, notably in the case of land, public interest litigation is not a feature of the legal system. Theoretically of course, decisions of government on the allocation of resources for healthcare could be challenged by way of judicial review, or, in the Pacific context, by destabilising the government. Judicial review in the context of health provision may not, however, be straightforward. Even in countries which have a limited land mass, such as Fiji, the geographical spread of people

and poor infrastructure can mean that the allocation of health care and other resources is devolved more remotely, for example to provincial government, to hospitals and to rural healthcare centres. In developing countries donor aid programmes, agendas or agencies may also have an influence or priorities for 'progressive achievement'. In other words the politics of others are involved. Nevertheless if there is too much deference to the separation of powers and the prerogative of the executive to determine what resources are allocated to healthcare for children then there is a danger that a minimum core of rights will not be met. What needs to be achieved therefore for an optimum outcome is a compromise between positive action by the court on the one hand, and consideration of consequences of judicial intervention on the other hand.

While Fiji does not have a separate constitutional court and is not a state party to the CESC, if comparative jurisprudence is finding (as in Columbia) that there is a minimum core of fundamental health care rights for children, or that reasonableness may be a key measure of progressive realisation (as in South Africa) and if, as is explicit in the Fiji Constitution, international law may be called into play, then the highest courts in Fiji may find themselves confronted by the types of dilemmas considered above and have to rule accordingly. At the same time, if, as a comparative analysis might suggest, countries are moving towards recognising a minimum core right to health then, as indicated in discussion of the *Samity* case above, it may be incumbent on wealthier nations to assist Fiji in delivering on the expectations its new Constitution may have raised.¹⁵⁰

¹⁵⁰ Hunt (n 65).

Appendix 2

Realising the Right to Health for Young People in South Africa—Some Reflections

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Realising the Right to Health for Young People in South Africa—Some Reflections

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ABSTRACT *The right to health is enshrined in the South African Constitution as well as a range of international and regional human rights treaties which South Africa accepts. Yet empirical data reveals some of the challenges faced by South African youth—childhood diseases, HIV/AIDS and such like. There are evidently challenges realising the right to health in practice. Nevertheless, South African courts have led the international field in recognising the justiciability of economic and social rights such as the right to health. Having reviewed the applicable laws and jurisprudence, the paper will conclude that a more holistic human rights-based approach offers perhaps the best way forward.*

KEY WORDS: South Africa, health, human rights-based approach, youth, challenges

Introduction

This paper will reflect on the right to health of young people in South Africa. The right to health is enshrined in the South African constitution as well as a range of international and regional human rights treaties which South Africa accepts. Moreover, South African courts have led the international field in recognising the justiciability of economic and social rights such as the right to health. As recent

reports indicate, however, there are many health-related challenges facing the country's youth. This paper thus adopts a human rights based approach to the question how can the right to health of young people in South Africa be better guaranteed?

A brief overview of data on the health of young people in South Africa

For many young people, the right to health is almost taken for granted, having survived infancy. After all many countries still have high infant mortality rates and a relatively low life expectancy. For this overview of the position in South Africa, data is taken from the annual data published by UNICEF in its State of the World's Children Report (UNICEF, 2014) and the UN Development Programme's Human Development Report 2014 (UNDP, 2014). The 2015 versions of each report will not be published until the end of 2015 but both reports provide data on all UN member states. According to the UN Development Programme, South Africa ranks 118th on its 2014 Human Development Index, placing it squarely in the medium development state category (UNDP, 2014). This index is 'a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and have a decent standard of living. The HDI is the geometric mean of normalized indices for each of the three dimensions.'ⁱ South Africa has risen upwards to a higher level of development achievement. However, drilling into the figures, the issue of health looms large. South Africa ranked fifty-eighth in the world, out of 194 states, in terms of under five mortality rates (first being the worst as the ranking is in descending order) although the statistics indicate a decline from 61 to 44 deaths per 1,000 live births (UNICEF, 2014: 30, 39). Life expectancy at birth is barely fifty-seven years (UNICEF, 2014: 39; UNDP, 2014). Many African states, including Commonwealth states rank above South Africa and thus have even higher levels of under-five mortality rates.

Looking at health indicators quoted in the annual State of the World's Children report issued in December each year by UNICEF, a total of 95% of households have improved drinking water (99% in urban areas) and an average of 74% have improved sanitation in households (UNICEF, 2014: 52). This is obviously a positive indicator of developmental progress, not least towards the UN millennium development goals. Over sixty percent of children receive core immunisation, with 84% receiving BCG immunisations (UNICEF, 2014: 52). However, according to the data presented, some forty percent of children had had diarrhoea immediately prior to the survey and had treatment with oral rehydration salts. Diarrhoea remains a threat to the health and life of many children and younger people around the world, not least in Africa. Looking more specifically at issues affecting youth, UNDP notes that there are 50.9 births per 1,000 girls aged fifteen to nineteen (UNDP, 2014). This figure should be viewed in light of the maternal death rates and the HIB/AIDS data. Three hundred women die per one hundred thousand live births (UNDP, 2014) and the statistics for HIV/AIDS indicate the continuing scale of the problem in the country (and indeed region). For the 2013 statistics quoted, 19.1% of those aged 15-49 are living with HIV, over six thousand people in total; 8.6 percent of young people aged 15-24 are recorded as living with HIV and barely a quarter of young people: (1) could correctly identify the main ways of preventing the sexual transmission of HIV; (2) rejected the local misconceptions about transmission; and (3) knew that a healthy looking person can be HIV-positive (UNICEF, 2014: 58). For eastern and southern Africa as a region, the young person prevalence rate is 2.7%, still the highest region in the survey, but considerably lower a statistic than that of South Africa alone (UNICEF, 2014: 59), indeed, South Africa is recorded as having by far the highest prevalence rate for young people of any country.

It is clear from this brief overview, and other data sources reveal similar statistics, that the youth of South Africa are some way distant from experiencing the full

realisation of their right to health. What expectation should people have of their right to health?

The right to health in South African and international laws

Section 27 of the Bill of Rights enshrined in Chapter 2 of the South African Constitution of 1996 proclaims that everyone has the right to access healthcare services and no one can be refused urgent medical treatment. According to section 28 of the same, specific provision for basic health care services extends to all those under the age of eighteen. The highlighting of children's rights, with the age of eighteen, reflects the terms of Article 1 UN Convention on the Rights of the Child, one of several treaties South Africa has ratified.

South Africa has ratified seven of the nine designated core UN human rights treaties including (of particular relevance to the right to health), the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women and, in January 2015, the International Covenant on Economic, Social and Cultural Rights.ⁱⁱ South Africa thus accepts many international treaty obligations on the rights to health, including Article 12 of the International Covenant on Economic, Social and Cultural Rights, Article 24 of the Convention on the Rights of the Child.

The right to health is discussed in a range of literature but for the working definition and application of the UN treaty right, it is necessary to consider the work of the UN Committee on the Rights of the Child, the principal entity reviewing children's rights within the UN treaty framework, which focussed on the children's right to health in a 2013 General Comment (UN CRC 2013). General comments indicate the view of the committee on, in this instance, a particular right in the treaty.

Article 24 of the UN Convention on the Rights of the Child provides:

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
 - (a) To diminish infant and child mortality;
 - (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
 - (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
 - (d) To ensure appropriate pre-natal and post-natal health care for mothers;
 - (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
 - (f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the

right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

The vagueness of the standards in some articles of the convention have led commentators to suggest that the rights are more idealistic goals and aspirations than tangible guarantees with legal effect (Burman, 1993: 50; Freeman, 1997). The UN guidance in its general comment is thus particularly valuable.

Young women are additionally protected against discrimination in access to health services in terms of Articles 11(1)(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women with general discrimination on grounds of race in relation to health proscribed by Article 5(e)(iv) of the Convention on the Elimination of all Forms of Racial Discrimination. Of these four key treaties, the jurisdiction of the UN monitoring committee of expertsⁱⁱⁱ to consider individual complaints (a quasi judicial procedure) is recognised by South Africa only in respect of the Convention on the Elimination of All Forms of Discrimination Against Women. However, South Africa does submit its reports on performance to the relevant UN committees, albeit not always on time - (there are no real penalties for late or non-submission). Its second report to the Committee on the Rights of the Child was due July 2002, yet only submitted November 2014.^{iv} It has not yet been considered. Its first report to the Committee on Economic Social and Cultural Rights is not yet due. The formal, international acknowledgement of a child's right to healthcare is promising but is far from a guarantee of promotion and implementation. Youth are mentioned but in passing. Moreover, international treaties may be meaningless, if as Tomás (2008: 6) writing on the Convention on the Rights of the Child highlights:

if there is no effective supervision over and enforcement of the way in which each country promotes and guarantees the CRC, besides the periodical writing of reports fo *[sic]* the International Committee on the Rights of the

Child, it is foreseeable that in a decade's time, we will still be able to say only that it is the most ratified international document; the rights to protection, to provision and to participation are universally recognised for children but the problem resides in the way they are, or are not, put into practice.

Freeman has suggested that if the Committee is to remain the fulcrum of enforcement, it should be permanent and given more powers, (2000: 290) and Navi Pillay, the former UN High Commissioner for Human Rights, has herself admitted that economic, social and cultural rights lack 'appropriate enforcement mechanisms at the international level' (2009: 2). It has been suggested, for example, that the reporting system lacks teeth (Freeman, 2000: 290), as there is little that can be done in the way of legal sanctions should a state choose to ignore the concluding observations and it can be argued that this has led to the lackadaisical attitude of many countries towards the reporting process (Bates, 2007). On the other hand, the reporting procedure can be viewed as a positive exercise that leads to open dialogue and inclusiveness, involving an honest appraisal and assisting states by highlighting areas where help (eg technical assistance) is needed.

At the regional level, monitoring and enforcement does not fare much better. However, within the African Union, South Africa is party to the African Charter on Human and Peoples' Rights, the African Charter on the Rights and Welfare of the Child, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and, of particular relevance, the African Youth Charter. This instrument applies to every person between the ages of fifteen and thirty-five years. Article 16 makes provision for the right to health and states:

1. Every young person shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties shall undertake to pursue the full implementation of this right and in particular shall take measures to:

- a) Make available equitable and ready access to medical assistance and health care especially in rural and poor urban areas with an emphasis on the development of primary health care;
- b) Secure the full involvement of youth in identifying their reproductive and health needs and designing programmes that respond to these needs with special attention to vulnerable and disadvantaged youth;
- c) Provide access to youth friendly reproductive health services including contraceptives, antenatal and post natal services;
- d) Institute programmes to address health pandemics in Africa such as HIV/AIDS, tuberculosis and malaria;
- e) Institute comprehensive programmes to prevent the transmission of sexually transmitted infections and HIV/AIDS by providing education, information, communication and awareness creation as well as making protective measures and reproductive health services available;
- f) Expand the availability and encourage the uptake of voluntary counselling and confidential testing for HIV/AIDS;
- g) Provide timely access to treatment for young people infected with HIV/AIDS including prevention of mother to child transmission, post rape prophylaxis, and anti-retroviral therapy and creation of health services specific for young people;
- h) Provide food security for people living with HIV/AIDS;
- i) Institute comprehensive programmes including legislative steps to prevent unsafe abortions;
- j) Take legislative steps such as banning advertising and increasing price in addition to instituting comprehensive preventative and
- g) Institute incentive schemes for employers to invest in the skills development of employed and unemployed youth;

- h) Institute national youth service programmes to engender community participation and skills development for entry into the labour market.
- j) Take legislative steps such as banning advertising and increasing price in addition to instituting comprehensive preventative and curative programmes to control the consumption of tobacco, exposure to environmental tobacco smoke and alcohol abuse;
- k) Raise awareness amongst youth on the dangers of drug abuse through partnerships with youth, youth organisations and the community;
- l) Strengthen local, national, regional and international partnerships to eradicate the demand, supply and trafficking of drugs including using youth to traffic drugs;
- m) Provide rehabilitation for young people abusing drugs such that they can be re-integrated into social and economic life;
- n) Provide technical and financial support to build the institutional capacity of youth organisations to address public health concerns including issues concerning youth with disabilities and young people married at an early age.

This provision is considerably more detailed than the core provisions in international human rights law. Raising awareness is a common theme and lends support to national strategies on promotion of health and healthy choices. This links to the empowering/education element of a human rights based approach, as will be discussed below. As with so many treaties, the provisions are binding only on the parties thereto – that is to say, the states.

If responsibility rests with national governments (Easley et al, 2001), then it is necessary to first identify the scope of the right and then examine the opportunities for enforcing the right in terms of national law. As noted above, South Africa has

one of the most comprehensive rights-orientated written constitutions, with extensive provisions guaranteeing human rights, including the right to health.

All states are required to protect, promote and respect accepted human rights. Respecting human rights can be achieved through omission – not acting directly to violate the right, but more often protecting human requires positive legislative and policy measures, as well as the dedication of resources. Enshrining rights in the constitution is an important public indication of commitment towards protecting human rights. However, it is not necessarily enough for states to tabulate human rights in a constitution, it is important that such rights are meaningful and can be enforced, as a first step the promotion of human rights is important. Promoting human rights requires generating awareness of the right and the remedies available for any infringement. Article 16 of the African Youth Charter gives strong guidance on the former.

Healthcare and health services must be available, accessible, acceptable, and scientifically and medically of good quality for all recipients. Paul Hunt, the first UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health used this framework for assessing the realising of the right to health around the world.^v General comment 14 of the UN Committee on Economic, Social and Cultural Rights explains it in more detail (UN CESCR, 2000).

What then happens if someone is refused access to healthcare, or if the healthcare available is too expensive? It appears from the foregoing that the onus is on states to provide the level of care commensurate with the treaty obligations they have accepted. If states fail in this endeavour, then recourse to the international and regional mechanisms is a distant possibility and relatively weak. Individuals must first consider national law and national remedies. Central to the full realisation of the

right to health is thus the capacity of a victim of an alleged infringement to hold the state authorities to account.

Litigating the right to health

Rights in the South African Constitution can be considered by the constitutional court. From the very beginning of post-apartheid South Africa there were challenges to the constitutional court's ability to adjudicate on economic, social and cultural rights culminating in "the First Certification case" (*Ex parte Chairperson of the Constitutional Assembly: in re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC)). Here the very inclusion of economic, social and cultural rights within the Constitution was challenged on the grounds that it was against the separation of powers doctrine because it would lead the court to make decisions, especially budgetary, that are the prerogative of the other branches of government. The court based its response on a well established argument: that adjudicating economic, social and cultural rights (ESC rights) is no different from adjudicating civil and political rights, in that both sets of rights can have a significant budgetary impact, and that as the justiciability of civil and political rights is not contested on this ground, neither can the justiciability of economic social and cultural rights be contested (Yamin, 2008: 52). The court ruled there was no breach of separation of powers (para 77). In response to another more general argument that such rights are not justiciable, the court held that '[W]e are of the view that these rights are, at least to some extent, justiciable' (para 78). The court therefore made it very clear that ESC rights were justiciable and expressly acknowledged its own jurisdiction over such matters (see also Ngwena, undated). Berger (2010) points out that these short arguments put an end to the debate about the justiciability of such rights in South Africa though further litigation suggests the issue was not so clear.

Part of the claimed problem lies in the perceived vagueness of the precise conditions necessary to fulfil (in this case) the right to adequate healthcare. What is adequate? How much budget should a state spend on healthcare? In answer to that, the African Union countries pledged in the 2001 Abuja Declaration to spend fifteen percent of their budget on health. Mauritius and the Seychelles were first on track to meet this figure. Not all regions have the same approach. The lack of perceived specificity, however, cannot be a barrier to litigating rights such as to health. The UN Committee on Economic, Social and Cultural Rights and the UN Committee on the Rights of the Child are clear on this. Both these committees can accept and consider complaints on, inter alia, the right to health. The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (UN Doc E/CN.4/1987/17, annex) whilst noting that rights in the Covenant are to be achieved progressively (Article 2), states that some rights can be made immediately justiciable (para 8). Paragraph 72 elaborates on the criteria for proving a violation of a right – these include deliberately failing to meet a standard of achievement which is within the powers of a government to meet or retarding/ halting progress towards a right for reasons other than a lack of available resources or force majeure.

In South Africa, the right to healthcare and access to medical treatment was initially litigated in *Soobramoney v. Minister of Health (Kwazulu - Natal)* (1) SA 765 (CC) which came before the Constitutional Court in 1998. Soobramoney was a 41 year old man who needed kidney dialysis to survive and was claiming this from the state, having exhausted funds to pay for it privately. Soobramoney was in the final stages of chronic renal failure, his condition was irreversible, and he also suffered from diabetes, heart and vascular disease, meaning he was not a candidate for a transplant and therefore did not fall within the guidelines for state support - guidelines which were in place because of a claimed lack of resources. The court

ruled in favour of the state. The court accepted the resource limits of the state, noting that it had actually over-spent on its budget (para 24), and appreciated the 'difficult decisions to be taken at the political level in fixing the health budget' (at para 29). The deference to the state to decide what was best given these budgetary constraints was the beginning of an important test of reasonableness which can be found throughout the South African jurisprudence on economic, social and cultural rights. Berger suggests that *Soobramoney* shows that a right to healthcare 'does not impose an obligation on the state to provide everything to everyone' (at 54). The case of *Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC) challenged this concept of 'reasonableness' in limiting or extending access to healthcare. TAC was challenging the government's policy on the ARV drug *nevirapine* which would prevent mother to child transmission of HIV. The drug was only available at a limited number of centres which focused on research because the government questioned its safety and effectiveness as well as questioning the connection between HIV and AIDS. The government's defence was based on the need for continued research and a lack of resources to roll out the programme and provide the drug nationally. Key to defeating this argument, however, was that *nevirapine* had been provided free of charge to South Africa for five years by the German manufacturers Boehringer Ingelheim and that even without the full supporting programme the drug would still save many lives (para 57). Thus it was found unreasonable for the government not to provide the drug at state hospitals and the court therefore required the South African government 'to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV' (para 135). The court went further by ordering *nevirapine* to be made available at other state hospitals that were not research sites and allowing its use to prevent mother to child transmission of HIV.

This is perhaps as specific as the South African Court has been with regards to directing government actions in this context. Nolan, however, points out the problems of the court's jurisprudence in not accepting direct and immediate obligations to ensure a child's right to healthcare stating that:

The *TAC* decision is an example of a court displaying reluctance to require the State to do more than to achieve the progressive realisation of the child's right to health within that State's maximum resources. Indeed, in doing so, the Court arguably ignored the text and purpose underlying the particular constitutional provision setting out the child's right to health at issue in the case (Nolan, 2010: 151).

These South African cases suggest that a certain combination of elements may provide the right model for giving effect to the right to healthcare: the codification of economic, social and cultural rights in a constitution; an appropriate court judgment which considers cases with regards to collective – rather than individual, rights; and deference to government making difficult resource allocation decisions. Tobin support this, noting:

[T]here is a need for caution when assessing the justiciability of the right to health in international law by reference to its treatment in regional and domestic forums . . . At the same time, the comparative exercise can be used to demonstrate the justiciability of the right to health in international law and in this respect two cases arising under the South African Constitution are particularly revealing . . . [The Constitutions] formulation of the right to health, with its focus on access to health care services, is narrower than the formulation adopted in international law. But accessibility is still a core element of the right to health in international law and the progressive nature

of the obligation under the South African Constitution is consistent with the obligation in international law (Tobin, 2011: 205).^{vi}

The constitutional court itself, in the *TAC* case noted that:

The Constitution contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions *achieve appropriate constitutional balance* (para 38, emphasis added).

Setting aside the complex arguments on budgetary implications of court decision, what is promising is the willingness of the South African court to consider claims of violations of the right to health. It is clear that, unlike many countries, it can therefore be litigated.

A human rights based approach to realising the right to health

Litigation should, of course, be a last resort, and in any event is not a remedy particularly accessible to many youth – accessibility is a major factor, although many non-governmental organisations are active in the region and have locus standi to bring complaints as the *TAC* case demonstrates. This brings us to the last section of the paper advocating a human rights based approach to realising the right to health. The explicit formulation of a human rights based approach dates to the 2003 UN Common Understanding on Human Rights Based Approaches to Development Cooperation and Programming. This conceptual framework sought to

ensure more consistency between UN agencies and programmes. The three key elements of the common understanding translate well to realising the right to health:

- 1) The state should ensure all its laws and policies respect and promote human rights
- 2) Human rights standards should guide and develop all laws and policies
- 3) The state should support duty bearers in discharging their obligations and rights holders in claiming their rights.^{vii}

In South Africa's case, as was discussed above, the framework of laws is already in place to respect youth health rights. Whether human rights standards do guide laws and policies is beyond the scope of this paper. Clearly they do to an extent as the constitution imposes obligations on the government, as do the various regional and international human rights treaties. Where great progress could be made, however, is the third element. This can be read as requiring the state to ensure that all state health professionals are aware of their obligations to protect the right to health of those they treat (or who can expect to be treated). A human rights perspective should thus govern their work. Ford (2006: 188-189) writing on female genital cutting in southern Africa thus argues for shifting the focus from its traditional negative perspective (what is being done wrong; characterising cultural practices as harmful or a problem; aiming at individual change; and [imposing] prescribing expert-driven solutions) to a more inclusive participatory approach developing dialogues with the people concerned and working more holistically. Such an approach clearly has relevance for many health issues, including HIV. Given the low statistical information on success of communication on HIV in South Africa, for example as outlined above, it is clear that current approaches are either not working or are working too slowly. Health demands more than just laws and policies, a holistic strategy is necessary to achieve increases in the enjoyment of health, not

least against the indicators discussed at the start of this paper. Laws alone cannot reduce HIV/AIDS transmission or increase youth awareness of the virus. Similarly, laws alone cannot reduce teenage pregnancy or maternal deaths. The issues and challenges are complex and interrelated.

The desirability of a holistic approach is clearly evident in the literature on human rights education and the second part of the third element: awareness of rights holders. If young people do not know of their right to health in terms of the constitution, laws, policies and treaties, they are unlikely to be able to take action to enforce those rights. Moreover, the reality is that their right to health will be better realised by ensuring they know how to be healthy and have access to healthcare when required and access to information otherwise. For example the UN Committee on Economic, Social and Cultural Rights explains that the right to health in the Covenant includes provision of a safe environment for adolescents, enabling them 'to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make.' (UN CESCR, 2000: 7). This explicitly includes 'youth friendly health care' respecting confidentiality and privacy of the individual. A multitude of non-governmental organisations, civil society entities, grass roots activists, foreign technical assistance and development aid and, of course, state projects, aim at ensuring young people are aware of threats to their health, how to protect their own health and how to engage with health professionals and state healthcare provision. Yet still the data indicate failings in realising the right to health of young people in South Africa.

Conclusion

South Africa and its regional and international partners have the potential to direct resources more effectively towards securing the right of health of young people in

the country. Key areas have been targeted, including HIV/AIDS though obviously more has to be done. A more holistic approach and better education, broadly construed, is posited as the way forward.

ⁱ Taken from the UNDP explanation at <<http://hdr.undp.org/en/content/human-development-index-hdi>> accessed 8/09/2015.

ⁱⁱ It has not yet signed or ratified the Convention on the Protection of the Rights of All Migrant Workers and their Families or the Convention for the Protection of All Persons from Enforced Disappearances.

ⁱⁱⁱ These are appointed under each individual treaty – a committee of experts receives and considers reports on each state's performance and engages in a constructive dialogue with the state.

^{iv} At the time of writing this was not yet published.

^v Note that none of the Special Rapporteurs on Health have undertaken a country visit to South Africa although South Africa has issued a standing invitation to all special procedures.

^{vi} The cases Tobin refers to are *Soobramoney* and *TAC*.

^{vii} For information on the human rights based approach to development, see <http://hrbaportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies> accessed 12/09/15.

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